

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 10760 CERTIFICATE OF DEATH

10762

Reg. Dist. No. 116

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Dorchester</b>		STATE <b>Maryland</b>		COUNTY <b>Dorchester</b>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <b>Cambridge</b>		<b>Life</b>		TOWN <b>Cambridge</b>		<b>13</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Cambridge Md Hospital</b>				STREET ADDRESS (If rural give location) <b>1</b>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <b>Rolanda Dorsia Banks</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>Nov 17 19 55</b>			
<b>5. SEX</b> <b>Female</b>	<b>6. COLOR OR RACE</b> <b>Negro</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>single</b>	<b>8. DATE OF BIRTH</b> <b>9-18-55</b>		<b>9. AGE last birthday</b> yrs. <b>2</b>	<b>IF UNDER 1 YEAR</b> Months <b>2</b>	<b>IF UNDER 24 HRS.</b> Days <b>2</b> Hours <b>0</b> Min. <b>0</b>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Harold Leroy Cooper</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Rosa Lee Banks</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Miss Rosa Lee Banks</b> <b>Church Creek, Md.</b>			
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
<b>491X</b> IMMEDIATE CAUSE (A) <b>Bronchopneumonia</b>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b> <b>0</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> <b>21e. INJURY OCCURRED</b> White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>					
<b>22. I hereby certify that I attended the deceased from Oct. 1, 19 55, to Nov 17, 19 55, that I last saw the deceased alive on Nov 17, 19 55, and that death occurred at M, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <b>J. Edwin Fasset</b>				<b>ADDRESS</b> (Street, city, town, state) <b>227 Pine St-Cambridge, Md.</b>		<b>DATE SIGNED</b> <b>11-19-55</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>11-19-55</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Waugh Cemetery</b>		<b>LOCATION (City, town, or county)</b> <b>Cambridge-Dor-Md.</b>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <b>J. H. St. Clair, Jr.</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>J. H. St. Clair, Jr.</b>		<b>ADDRESS</b> <b>High St-Camb., Md.</b>	
<b>DATE</b> <b>11-19-55</b>							

107517235

# CERTIFICATE OF DEATH

1955

1. Name of deceased

2. Sex and age at death

3. Date of death

4. Place of death

5. Cause of death

6. Name of physician

7. Name of funeral director

8. Name of hospital

9. Name of cemetery

10. Name of registrar

BUREAU V. S.

NOV 29 1955

RECEIVED

RECEIVED

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 10782 CERTIFICATE OF DEATH

10763

Reg. Dist. No. 116

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Rural Cambridge</u>		<u>2 years</u>		TOWN <u>Rural Cambridge</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>At home</u>				<u>1</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>W. Woodrow Bramble</u>				<u>Nov. 24 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>M</u>	<u>W</u>	<u>M</u>	<u>August 26, 1916</u>	<u>39</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>General Manager</u>		<u>Auto Sales</u>		<u>Woolfords, Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Soloman F. Bramble</u>				<u>Effie Applegarth</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Yes</u> <u>World War II</u>		<u>213-12-5637</u>		<u>Mrs. Woodrow Bramble Cambridge, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
420.1 IMMEDIATE CAUSE (A)				<u>Coronary Infarction</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH			
				<u>1 1/2 hrs.</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<u>0</u>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8-2</u> , 19 <u>54</u> , to <u>11-24</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11-24</u> , 19 <u>55</u> , and that death occurred at <u>9:45</u> P.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>W. B. Bannan</u> M.D.				<u>Cambridge, Md.</u>		<u>11-26-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>11/27/55</u>		<u>Old Trinity Cemetery</u>		<u>Church Creek, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>11-27-1955</u>		<u>John Y. Haco, M.D.</u>		<u>LECOMPTE FUNERAL SERVICE</u>		<u>Cambridge, Md.</u>	

RECEIVED

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 10783 CERTIFICATE OF DEATH

10764

Reg. Dist. No. 116

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>DORCHESTER</u>		STATE <u>MARYLAND</u>		COUNTY <u>DORCHESTER</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>CAMBRIDGE PT. 2</u>		<u>3 Mos.</u>		TOWN <u>CAMBRIDGE PT. 2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>THOMAS MILLS HOME</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>ROBERT</u> (Middle) <u>R.</u> (Last) <u>BROHAWN</u>				Month <u>Nov.</u> Day <u>29</u> Year <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>M</u>	<u>W</u>	<u>W</u>	<u>MAR. 14 1885</u>	<u>70</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<u>FARMER</u>					<u>SALEM, Md.</u>		<u>U.S.A</u>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>JAMES BROHAWN</u>				<u>MARY CHRISTOPHER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>NO</u>		<u>218-20-6969</u>		<u>MRS THOMAS MILLS PT. 2, Md.</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) <u>Cerebral thrombosis</u>							<u>1 day</u>
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							<u>6-8 yrs.</u>
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					20. AUTOPSY?
<u>0</u>							YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County)	(State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7-3-45</u> , 19 <u>11-29-55</u> , to <u>11-29-55</u> , that I last saw the deceased alive on <u>11-29-55</u> , and that death occurred at <u>2:10P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Chas. B. Brubaker</u>				DATE SIGNED			
ADDRESS <u>M.D. 9 Race St., Cambridge, Maryland</u>				<u>11-30-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>BURIAL</u>		<u>12/1/55</u>		<u>EAST NEW MARKET</u>		<u>EAST NEW MARKET, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Dec 1, 1955</u>		<u>John Thaa, D. W. LeCompte</u>		<u>FUNERAL SERVICE</u>			



# 1073 CERTIFICATE OF DEATH

Wash. D.C. 20501

DATE OF DEATH

MARYLAND

COUNTY OF

CITY OF

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF RETURN

PLACE OF RETURN

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF RETURN

PLACE OF RETURN

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

INVESTIGATION

GENERAL INVESTIGATION

GENERAL INVESTIGATION

BUREAU V. S.

DEC 5 1955

RECEIVED

EXHIBITION

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10761

## CERTIFICATE OF DEATH

Reg. Dist. No.

10765

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Cambridge</u>		LENGTH OF STAY (in this place) <u>Life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cambridge</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>516 Pine St</u>				STREET ADDRESS (If rural give location) <u>516 Pine St</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Sophia J. Bromwell</u>				4. DATE OF DEATH: (Month) (Day) (Year) <u>Nov 27 19 55</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widow</u>	8. DATE OF BIRTH: <u>May 4, 1866</u>	9. AGE last birthday <u>89</u> yrs.	IF UNDER 1 YEAR Months Days Hours Mln.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: - - - -		11. BIRTHPLACE (State or foreign country): <u>Dorchester-Co-Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Richard Jolley</u>				14. MOTHER'S MAIDEN NAME: <u>Nancy Bailey</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>9</u> - - - -		16. SOCIAL SECURITY NO. - - - - -		17. INFORMANT & ADDRESS: <u>Maggie Waters- Cambridge, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.0 IMMEDIATE CAUSE (A) <u>Cardiac Decompensation</u>							
ANTECEDENT CAUSE (S) DUE TO (B) <u>Hypertensive Arteriosclerotic Heart Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov 20, 19 55</u> to <u>Nov 27, 19 55</u> , that I last saw the deceased alive on <u>Nov 27, 19 55</u> , and that death occurred at <u>M, from the causes and on the date stated above.</u> SIGNATURE <u>Edwin Fassett, M.D.</u> ADDRESS <u>227 Pine St-Camb., Md.</u> DATE SIGNED <u>Nov 29, 1955</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11-29-55</u>		NAME OF CEMETERY OR CREMATORY <u>Oldfield Cemetery</u>		LOCATION (City, town, or county) (State) <u>Oldfield-Dor-Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Nov. 29, 1955</u>		REGISTRAR'S SIGNATURE <u>J. H. Hale, Jr.</u>		24. FUNERAL DIRECTOR <u>H. M. StClair, Jr.</u>		ADDRESS <u>-High St-Camb., Md.</u>	

BUREAU V. S.

NOV 30 1955

RECEIVED



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10762

## CERTIFICATE OF DEATH

10766

Reg. Dist. No. 116

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
13 TOWN <u>Cambridge</u>		<u>lifetime</u>		OR TOWN <u>Cambridge</u>		13	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
67 <u>Cambridge Md. Hosp.</u>				<u>105 Peachblossom Ave.</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>EUGENE D. BROOKS</u>				<u>Nov. 14 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>M</u>	<u>W</u>	<u>M</u>	<u>Nov. 24, 1895</u>	<u>59</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Merchant</u>		<u>Grocery</u>		<u>Woolford, Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Jefferson D. Brooks</u>				<u>Maranda Parker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No.</u>		<u>214-07-7320</u>		<u>Mrs. Brooks</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
331X IMMEDIATE CAUSE (A)				<u>Coronary occlusion</u>			
ANTECEDENT CAUSE(S) DUE TO				<u>Cerebral hemorrhage</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				<u>generalized arterio sclerosis</u>			
DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>				INTERVAL BETWEEN ONSET AND DEATH			
				<u>3 1/4 hours</u>			
				<u>1 month</u>			
				<u>4 yrs.</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10/18</u> , 19 <u>55</u> , to <u>11/14</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11/14</u> , 19 <u>55</u> , and that death occurred at <u>11/15</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Lawrence Maryanor</u>				ADDRESS (Street, city, town, state) <u>M.D. 136 Rue St. Cambridge, Md</u>			
DATE SIGNED <u>11/15/55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>11/17/55</u>		<u>Dorchester Memorial Park</u>		<u>Cambridge Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
		<u>John P. Lee, R. O.</u>		<u>LECOMPTE FUNERAL SERVICE</u>		<u>Cambridge Md.</u>	
DATE <u>Nov. 17, 1955</u>							

# CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "JOHN J. SMITH"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]	
DATE OF DEATH [Faint text, possibly "Nov 22 1955"]		PLACE OF DEATH [Faint text, possibly "Home"]		TIME OF DEATH [Faint text, possibly "10:30 AM"]	
CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]		PLACE OF INTERMENT [Faint text, possibly "St. Mary's Cemetery"]	
SIGNATURE OF PHYSICIAN [Faint signature]		SIGNATURE OF CORONER [Faint signature]		SIGNATURE OF REGISTRAR [Faint signature]	
CERTIFICATE NO. [Faint number, possibly "12345"]		COUNTY [Faint text, possibly "Baltimore"]		CITY [Faint text, possibly "Baltimore"]	

**RECEIVED**  
 NOV 22 1955  
 BUREAU V. S.

This certificate is to be used for the purpose of recording the death of a person who has died in the State of Maryland. It is to be filled out by the physician who attended the deceased, or by the coroner if the death was sudden or unexpected. The certificate should be filed in the office of the Registrar of the Department of Health, Baltimore, Maryland.

## INSTRUCTIONS

**1**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 10763 CERTIFICATE OF DEATH

10767

Reg. Dist. No. 116

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Dorchester</u>		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cambridge</u>		LENGTH OF STAY (in this place) --		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cambridge</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>6 Green Street</u>		STREET ADDRESS (If rural give location) <u>6 Green St.</u>					
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>Harry L. Buchanan</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>11 7 1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u>	8. DATE OF BIRTH <u>6/13/72</u>	9. AGE last birthday <u>83</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nursery and seeds</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Buchanan</u>				14. MOTHER'S MAIDEN NAME <u>Not Known</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT & ADDRESS <u>John H. Buchanan 6 Green St. City</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
331X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis, generalized</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION <u>6</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> P. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <u>11/6</u> , 19 <u>55</u> , <b>to</b> <u>11/7</u> , 19 <u>55</u> , <b>that I last saw the deceased alive on</b> <u>11/7</u> , 19 <u>55</u> , <b>and that death occurred at</b> <u>4:15</u> P.M., <b>from the causes and on the date stated above.</b> <b>SIGNATURE</b> <u>Lawrence Maryanor</u> M.D. <b>ADDRESS</b> (Street, city, town, state) <u>Cambridge Md.</u> <b>DATE SIGNED</b> <u>11/8/55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11-9-55</u>		NAME OF CEMETERY OR CREMATORY <u>Brick Church Yard</u>		LOCATION (City, town, or county) (State) <u>Taylors Island Md.</u>	
24. REC'D BY REGISTRAR <u>John Doe, M.D.</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u>		ADDRESS <u>Cambridge, Md.</u>	

10751

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

# 10751 CERTIFICATE OF DEATH

Form No. 10751

1. NAME OF DECEASED

NAME OF DECEASED  
DATE OF BIRTH  
PLACE OF BIRTH  
OCCUPATION  
EDUCATION  
MARRIAGE

MARRIAGE

1. NAME OF DECEASED

DATE OF BIRTH  
PLACE OF BIRTH  
OCCUPATION  
EDUCATION  
MARRIAGE

2. PLACE OF DEATH

2. PLACE OF DEATH

2. PLACE OF DEATH

3. CAUSE OF DEATH

3. CAUSE OF DEATH

3. CAUSE OF DEATH

4. TIME OF DEATH

4. TIME OF DEATH

4. TIME OF DEATH

5. SIGNATURE OF DECEASED

5. SIGNATURE OF DECEASED

5. SIGNATURE OF DECEASED

6. SIGNATURE OF WITNESSES

6. SIGNATURE OF WITNESSES

6. SIGNATURE OF WITNESSES

7. SIGNATURE OF PHYSICIAN

7. SIGNATURE OF PHYSICIAN

7. SIGNATURE OF PHYSICIAN

8. SIGNATURE OF CORONER

8. SIGNATURE OF CORONER

8. SIGNATURE OF CORONER

9. SIGNATURE OF JURY

9. SIGNATURE OF JURY

9. SIGNATURE OF JURY

10. SIGNATURE OF JUDGE

10. SIGNATURE OF JUDGE

10. SIGNATURE OF JUDGE

11. SIGNATURE OF CLERK

11. SIGNATURE OF CLERK

11. SIGNATURE OF CLERK

12. SIGNATURE OF NOTARY

12. SIGNATURE OF NOTARY

12. SIGNATURE OF NOTARY

13. SIGNATURE OF DECEASED

13. SIGNATURE OF DECEASED

13. SIGNATURE OF DECEASED

14. SIGNATURE OF WITNESSES

14. SIGNATURE OF WITNESSES

14. SIGNATURE OF WITNESSES

15. SIGNATURE OF PHYSICIAN

15. SIGNATURE OF PHYSICIAN

15. SIGNATURE OF PHYSICIAN

16. SIGNATURE OF CORONER

16. SIGNATURE OF CORONER

16. SIGNATURE OF CORONER

RECEIVED  
NOV 22 1955  
BUREAU V. S.

20010751

## 10784 CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Dorchester</i> MARYLAND	CITY (If outside corporate limits, write RURAL and give nearest town) <i>Cambridge</i> LENGTH OF STAY (in this place) <i>1 month</i>	STATE <i>Maryland</i> COUNTY <i>Wicomico</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Bivalve</i> 22x2
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Eastern Shore State Hospital</i>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (First) <i>LLOYD</i> (Middle) <i>NELSON</i> (Last) <i>CADE</i>		4. DATE (Month) (Day) (Year) OF DEATH: <i>11-17-1955</i>	
5. SEX: <i>Male</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Married</i>	8. DATE OF BIRTH: <i>9-5-1888</i>
9. AGE last birthday: <i>67</i> yrs.		IF UNDER 1 YEAR: Months <i>2</i> Days <i>12</i> IF UNDER 24 HRS.: Hours <i></i> Min. <i></i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>CLERK</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>TRANSPORTATION</i>	
11. BIRTHPLACE (State or foreign country): <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME: <i>George E. Cade</i>		14. MOTHER'S MAIDEN NAME: <i>Clara Alberta Barlow</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If yes, give war or dates of service) <i>unk.</i>		16. SOCIAL SECURITY NO. <i>166-01-4079</i>	
17. INFORMANT & ADDRESS: <i>Eastern Shore State Hospital records</i>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <i>Arteriosclerotic Heart Disease</i>		<i>1 year +</i>	
ANTECEDENT CAUSE (B) <i></i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <i></i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Duodenal Ulcer</i>		<i>Several years</i>	
19A. DATE OF OPERATION: <i>None</i>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>10-17, 1955</i> to <i>11-17, 1955</i> , that I last saw the deceased alive on <i>11-17, 1955</i> , and that death occurred at <i>9:42 P.M.</i> from the causes and on the date stated above.			
SIGNATURE <i>George E. Cade</i> M.D.		DATE SIGNED <i>11-17-55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Buried</i>		DATE THEREOF <i>11/24/55</i>	
NAME OF CEMETERY OR CREMATORY <i>St. Mary's Cem.</i>		LOCATION (City, town, or county) (State) <i>Luxemburg, Maryland</i>	
DATE REC'D BY LOCAL REGISTRAR <i>Nov 20, 1955</i>		REGISTRAR'S SIGNATURE <i>John Mac...</i>	
24. FUNERAL DIRECTOR <i>C. H. Messing, Bivalve, Maryland</i>		ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 22 1955

BUREAU V. S.



10764

10769  
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

No. 116

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY	Dorchester		MARYLAND	STATE	Md. COUNTY Dor.
CITY (If outside corporate limits, write RURAL OR and give nearest town)	TOWN Cambridge		LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town)	TOWN Cambridge
HOSPITAL OR INSTITUTION OR STREET ADDRESS	157 Washington St.		STREET ADDRESS	(If rural, give location) 157 Washington St.	
3. NAME OF DECEASED:	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month) (Day) (Year)
(Type or Print)	ALBERT	ARTHUR	DASHIELL	Nov.	23, 19 55
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR IF UNDER 24 HRS.
Male	Colored	Married	June 12, 1886	69 yrs.	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?	
Laborer	Seafood Packing		Maryland	USA	
13. FATHER'S NAME:			14. MOTHER'S MAIDEN NAME:		
Robert Dashiell			Tamer Waters		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:	
no		214-07-9906		Mrs. Elizabeth Dashiells Cambridge, Md	

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				5 min.	
420.1 Immediate cause (a) Coronary Occlusion DUE TO					
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO					
stating underlying cause last (c)					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE		M. D.		DATE SIGNED	
John M. [Signature]		M. D.		11/26-55	
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
Burial		11/27/55		Jesterville	
LOCATION (City, town, or county) (State)		24. FUNERAL DIRECTOR		ADDRESS	
Jesterville, Md.		Herbert St. Clair		Cambridge, Md.	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE			
Nov. 26, 1955		John V. [Signature]			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 29 1955

BUREAU V. S.

MARYLAND

STATE DEPARTMENT OF HEALTH

## 10765 CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Dor.</u>	
13. CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cambridge</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cambridge, Md.</u>	
67. HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cambridge Maryland</u>		STREET ADDRESS (If rural, give location) <u>Rural</u>	
3. NAME OF DECEASED (Type or Print) <u>John</u> (First) <u>J.</u> (Middle) <u>Dunn</u> (Last)		4. DATE OF DEATH (Month) <u>Nov.</u> (Day) <u>19</u> (Year) <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED <u>Married</u>	8. DATE OF BIRTH <u>10/10/1888</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Power Station</u>	9. AGE last birthday <u>67</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John H. Dunn</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Parrott</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>11-19-55</u>	
17. INFORMANT AND ADDRESS <u>Mrs John J. Dunn</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>30 hrs</u>
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
<p>443 X Immediate cause (a) <u>Cerebral Hemorrhage</u></p> <p>Antecedent cause(s) (b) <u>Hypertensive Cardiovascular Disease</u></p> <p>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)</p>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 11-18, 1955, to 11-19, 1955, that I last saw the deceased alive on 11-19-55, 1955, and that death occurred at 7:28 a.m., from the causes and on the date stated above.

SIGNATURE <u>Dr. Bannan</u>		ADDRESS <u>Cambridge</u>		DATE SIGNED <u>11-19-55</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE <u>11/21/55</u>		NAME OF CEMETERY OR CREMATORY <u>East New Market</u>	
LOCATION (City, town, or county) <u>East New Market Md.</u>		24. FUNERAL DIRECTOR <u>John S. Kellough</u>		ADDRESS <u>East New Market Md.</u>	
DATE REC'D BY LOCAL REG. <u>Nov. 21, 1955</u>		REGISTRAR'S SIGNATURE <u>John H. Dunn</u>		10.	

BUREAU V. S.

NOV 22 1955

RECEIVED

**INSTRUCTIONS**

**1**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10766

# CERTIFICATE OF DEATH

10771

Reg. Dist. No. 116

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Dorchester</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Dorchester</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
13 TOWN <b>Cambridge</b>				OR TOWN <b>Cambridge</b>		13	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
67 <b>Cambridge Md Hospital</b>				/			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<b>Barbara Jean Edwards</b>				<b>Nov 20 19 55</b>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
<b>Female</b>	<b>Negro</b>	<b>single</b>	<b>11-9-55</b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
				<b>Maryland</b>		<b>USA</b>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<b>Warren Edwards</b>				<b>Orine Johnson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<b>67 Robbins St Mrs. Orine Edwards-Cambridge, Md.</b>			
<b>18. MEDICAL CERTIFICATION</b>						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
762.5 IMMEDIATE CAUSE (A) <b>Premature-Atelectasis</b>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (B)							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. (C)							
19a. DATE OF OPERATION						19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)				21e. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Nov 9, 19 55</b> , to <b>Nov 20, 19 55</b> , that I last saw the deceased alive on <b>Nov 20, 19 55</b> and that death occurred at <b>11:24-55</b> M, from the causes and on the date stated above.							
SIGNATURE <b>J. Edwin Fassett,</b>				ADDRESS (Street, city, town, state) <b>227 Pine St-Cambridge, Md.-11-24-55</b>			
DATE <b>11-21-55</b>				DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>11-21-55</b>		<b>Waugh Cemetery</b>		<b>Cambridge-Dor-Md.</b>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
				<b>High St-Camb., Md.</b>			

42X5286390

103-1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 15

# 1036 CERTIFICATE OF DEATH

Page 1 of 1

1. DEATH OF DEATH

2. DEATH OF DEATH

3. DEATH OF DEATH

4. DEATH OF DEATH

5. DEATH OF DEATH

6. DEATH OF DEATH

7. DEATH OF DEATH

8. DEATH OF DEATH

9. DEATH OF DEATH

10. DEATH OF DEATH

11. DEATH OF DEATH

12. DEATH OF DEATH

13. DEATH OF DEATH

14. DEATH OF DEATH

15. DEATH OF DEATH

16. DEATH OF DEATH

17. DEATH OF DEATH

18. DEATH OF DEATH

19. DEATH OF DEATH

20. DEATH OF DEATH

21. DEATH OF DEATH

22. DEATH OF DEATH

23. DEATH OF DEATH

24. DEATH OF DEATH

25. DEATH OF DEATH

26. DEATH OF DEATH

27. DEATH OF DEATH

28. DEATH OF DEATH

29. DEATH OF DEATH

30. DEATH OF DEATH

31. DEATH OF DEATH

32. DEATH OF DEATH

33. DEATH OF DEATH

34. DEATH OF DEATH

35. DEATH OF DEATH

BUREAU V. S.

NOV 20 1955

RECEIVED

PROCTER



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 10767 CERTIFICATE OF DEATH

10772

Reg. Dist. No. 116

Item 9, Film G189 11-22-55 et

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Dorchester</u>		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
13 TOWN <u>Cambridge</u>		3yrs		TOWN <u>Cambridge</u> <u>Madison</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
67 <u>Cambridge Md. Hosp.</u>				<u>/</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
(First) COURTNEY (Middle) W. (Last) GEIB				11 12 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
M	W	M	2/25/1884	70/ 71 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Ser. Representative			Cad. Motor Car Co.		Hyattsville, Md.		U.S.A.
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
ADAM GEIB				MARIAH SPIER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS		
Yes World War 1			577-03-8842A		Mrs. Geib, Cambridge, Md.		
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
416X IMMEDIATE CAUSE (A)						Pulmonary Embolism	
ANTECEDENT CAUSE(S) DUE TO						Congestive Heart Failure	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.						Rheumatic Heart Disease	
(C)						30 yrs	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>						2 yrs	
19a. DATE OF OPERATION						19b. MAJOR FINDINGS OF OPERATION	
2						Perforation of Stomach - Cancer	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)			21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?		
M.			M.				
22. I hereby certify that I attended the deceased from June 1954, to Sep 12, 1955, that I last saw the deceased alive on Sep 12, 1955, and that death occurred at 1:15 P.M. from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
<u>W. B. Bannan</u> M.D.				<u>Cambridge</u> 11-12-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		11/15/55		Flint Hill, Virginia		Vienna, Virginia	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE		<u>Nov. 14, 1955</u>		<u>John H. H. D. LECOMPTE</u>		FUNERAL SERVICE Cambridge, Md.	



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 10768 CERTIFICATE OF DEATH

10773

Reg. Dist. No. 116

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Dorchester</u>		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cambridge</u>		<u>1 day</u>		TOWN <u>Golden Hill, Maryland</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cambridge Maryland Hospital</u>				STREET ADDRESS <u>/</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
(First) <u>FLORENCE</u> (Middle) <u>TALL</u> (Last) <u>GOOTEE</u>				Nov. 25 1955			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>F</u>	<u>W</u>	<u>M</u>	<u>Nov. 22, 1898</u>	<u>57</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Lakesville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Tall</u>				14. MOTHER'S MAIDEN NAME <u>Alexina Harper</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mr. Lowndes Gootee Golden Hill, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
IMMEDIATE CAUSE (A) <u>260X Coronary infarction</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1-2 min</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Cardiovascular disease</u>				<u>2 yrs.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Diabetes Mellitus</u>				<u>5 yrs.</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>2</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <u>2-9-55</u> <u>19</u> , to <u>11-25</u> , <u>1955</u> , that I last saw the deceased alive on <u>11-25</u> , <u>1955</u> , and that death occurred at <u>5:45</u> <u>PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>W. Bauman</u> M.D.				ADDRESS (Street, city, town, state) <u>Cambridge, Md.</u> DATE SIGNED <u>11-26-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Nov. 28, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Dorchester Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Cambridge Maryland</u>	
24. REC'D BY REGISTRAR <u>John Tall, Jr. D</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Nov. 28, 1955</u>				LECOMPT FURNAL SERVICE <u>Cambridge, Md.</u>			



10759

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. **10774**

No. **116**

1. PLACE OF DEATH: COUNTY <b>Dorchester</b> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>13</b> <b>Cambridge</b> LENGTH OF STAY (in this place) <b>entire life</b>				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <b>Maryland</b> COUNTY <b>Dorchester</b> CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <b>Cambridge</b> <b>13</b> STREET ADDRESS (If rural, give location) <b>1</b> <b>Shepherd Ave.</b>			
3. NAME OF DECEASED: (First) <b>Mitchell</b> (Middle) <b>Leroy</b> (Last) <b>Gould</b>				4. DATE OF DEATH <b>Nov. 15, 1955</b> 19			
5. SEX: <b>Male</b>		6. COLOR OR RACE: <b>White</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Married</b>		8. DATE OF BIRTH: <b>Nov. 21, 1915</b>	
9. AGE last birthday: <b>39</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <b>Optician</b>		11. BIRTHPLACE (State or foreign country): <b>Cambridge</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME: <b>James R. Gould</b>				14. MOTHER'S MAIDEN NAME: <b>Edith Willey</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>Yes</b>		16. SOCIAL SECURITY No.: <b>214-07-8005</b>		17. INFORMANT & ADDRESS: <b>Shepherd Ave. Mrs. Elizabeth H. Gould, Cambridge, Md.</b>			

18. MEDICAL CERTIFICATION I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: <b>420.1</b> Immediate cause (a) <b>Coronary Occlusion</b> DUE TO Antecedent cause(s) (b) _____ DISEASES OR CONDITIONS, IF ANY, giving rise to the above cause DUE TO stating underlying cause last (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <b>Nov. 17, 1955</b>		19b. MAJOR FINDING OF OPERATION:					
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) _____ (County) _____ (State) _____			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY _____ M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . SIGNATURE <b>John M. [Signature]</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>11-17-1955</b> M. D. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>							
23. BURIAL, CREMATION, REMOVAL (Specify): <b>Burial</b>		DATE THEREOF <b>Nov. 17, 1955</b>		NAME OF CEMETERY OR CREMATORY <b>Cambridge Cemetery</b>		LOCATION (City, town, or county) (State) <b>Cambridge, Md.</b>	
DATE REC'D BY LOCAL REG. <b>Nov. 17 1955</b>		REGISTRAR'S SIGNATURE <b>John M. [Signature]</b>		24. FUNERAL DIRECTOR <b>Kenneth R. Thomas, Cambridge, Md.</b>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 18 1955

BUREAU V. 2



**INSTRUCTIONS**

**1**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10785

**CERTIFICATE OF DEATH**

10775

Reg. Dist. No. 110

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Hurlock - Rural</u>		<u>Life</u>		TOWN <u>Hurlock - Rural</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
00 <u>Petersburg</u>				<u>Petersburg</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Bertha Mae Hughes</u>				<u>November 24 1955</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b> yrs.	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
<u>Female</u>	<u>Colored</u>	<u>Widowed</u>	<u>July 6, 1892</u>	<u>63</u>	Months	Days	Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>Housework</u>		<u>Home</u>		<u>Dorchester Co., Maryland</u>		<u>U.S.A.</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>Robert Aldridge</u>				<u>Emma Thompson</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<u>4 No</u>		<u>Unknown</u>		<u>Lillian V. Shephard, Philadelphia, Pa.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<u>443x</u> IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 wks</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension &amp; Chronic myocarditis</u>				<u>15 yrs.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (M.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>11/23</u>, 19<u>55</u>, to <u>11/24</u>, 19<u>55</u>, that I last saw the deceased alive on <u>11/24</u>, 19<u>55</u>, and that death occurred at <u>9:55</u> A.M., from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Frank M. Anderson</u> M.D.				<b>ADDRESS</b> (Street, city, town, state) <u>Federalsburg, Maryland</u>			
				<b>DATE SIGNED</b> <u>Nov. 26, 1955</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION</b> (City, town, or county) (State)	
<u>Burial</u>		<u>Nov. 27, 1955</u>		<u>Petersburg Cemetery</u>		<u>Near Hurlock, Maryland</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
DATE <u>Nov 27-1955</u>		<u>Charles Hastings</u>		<u>J.J. Frampton and Son, Federalsburg, Md.</u>			

10715

MAINTAINING STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

# CERTIFICATE OF DEATH

Form No. 10-1-55

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. MARITAL STATUS

8. EDUCATION

9. RELIGION

10. RACE

11. COLOR

12. SEX

13. AGE

14. DATE OF BIRTH

15. PLACE OF BIRTH

16. OCCUPATION

17. MARITAL STATUS

18. EDUCATION

19. RELIGION

20. RACE

21. COLOR

22. SEX

23. AGE

24. DATE OF BIRTH

25. PLACE OF BIRTH

26. OCCUPATION

27. MARITAL STATUS

28. EDUCATION

29. RELIGION

30. RACE

31. COLOR

32. SEX

33. AGE

34. DATE OF BIRTH

35. PLACE OF BIRTH

36. OCCUPATION

37. MARITAL STATUS

38. EDUCATION

39. RELIGION

40. RACE

41. COLOR

42. SEX

43. AGE

44. DATE OF BIRTH

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. MARITAL STATUS

8. EDUCATION

9. RELIGION

10. RACE

11. COLOR

12. SEX

13. AGE

14. DATE OF BIRTH

15. PLACE OF BIRTH

16. OCCUPATION

17. MARITAL STATUS

18. EDUCATION

19. RELIGION

20. RACE

21. COLOR

22. SEX

23. AGE

24. DATE OF BIRTH

25. PLACE OF BIRTH

26. OCCUPATION

27. MARITAL STATUS

28. EDUCATION

29. RELIGION

30. RACE

31. COLOR

32. SEX

33. AGE

34. DATE OF BIRTH

35. PLACE OF BIRTH

36. OCCUPATION

37. MARITAL STATUS

38. EDUCATION

39. RELIGION

40. RACE

41. COLOR

42. SEX

43. AGE

44. DATE OF BIRTH

45. PLACE OF BIRTH

46. OCCUPATION

47. MARITAL STATUS

48. EDUCATION

49. RELIGION

50. RACE

51. COLOR

52. SEX

53. AGE

54. DATE OF BIRTH

55. PLACE OF BIRTH

56. OCCUPATION

57. MARITAL STATUS

58. EDUCATION

59. RELIGION

60. RACE

61. COLOR

62. SEX

63. AGE

64. DATE OF BIRTH

65. PLACE OF BIRTH

66. OCCUPATION

67. MARITAL STATUS

68. EDUCATION

69. RELIGION

70. RACE

71. COLOR

72. SEX

73. AGE

74. DATE OF BIRTH

75. PLACE OF BIRTH

76. OCCUPATION

77. MARITAL STATUS

78. EDUCATION

79. RELIGION

80. RACE

81. COLOR

82. SEX

83. AGE

84. DATE OF BIRTH

85. PLACE OF BIRTH

86. OCCUPATION

87. MARITAL STATUS

88. EDUCATION

89. RELIGION

90. RACE

91. COLOR

92. SEX

93. AGE

94. DATE OF BIRTH

95. PLACE OF BIRTH

96. OCCUPATION

97. MARITAL STATUS

98. EDUCATION

99. RELIGION

100. RACE

101. COLOR

102. SEX

103. AGE

104. DATE OF BIRTH

105. PLACE OF BIRTH

106. OCCUPATION

107. MARITAL STATUS

108. EDUCATION

109. RELIGION

110. RACE

111. COLOR

112. SEX

113. AGE

114. DATE OF BIRTH

115. PLACE OF BIRTH

116. OCCUPATION

117. MARITAL STATUS

118. EDUCATION

119. RELIGION

120. RACE

121. COLOR

122. SEX

123. AGE

124. DATE OF BIRTH

125. PLACE OF BIRTH

126. OCCUPATION

127. MARITAL STATUS

128. EDUCATION

129. RELIGION

130. RACE

131. COLOR

132. SEX

133. AGE

134. DATE OF BIRTH

135. PLACE OF BIRTH

136. OCCUPATION

137. MARITAL STATUS

138. EDUCATION

139. RELIGION

140. RACE

141. COLOR

142. SEX

143. AGE

144. DATE OF BIRTH

145. PLACE OF BIRTH

146. OCCUPATION

147. MARITAL STATUS

148. EDUCATION

149. RELIGION

150. RACE

151. COLOR

152. SEX

153. AGE

154. DATE OF BIRTH

155. PLACE OF BIRTH

156. OCCUPATION

157. MARITAL STATUS

158. EDUCATION

159. RELIGION

160. RACE

161. COLOR

162. SEX

163. AGE

164. DATE OF BIRTH

165. PLACE OF BIRTH

166. OCCUPATION

167. MARITAL STATUS

168. EDUCATION

169. RELIGION

170. RACE

171. COLOR

172. SEX

173. AGE

174. DATE OF BIRTH

175. PLACE OF BIRTH

176. OCCUPATION

177. MARITAL STATUS

178. EDUCATION

179. RELIGION

180. RACE

181. COLOR

182. SEX

183. AGE

184. DATE OF BIRTH

185. PLACE OF BIRTH

186. OCCUPATION

187. MARITAL STATUS

188. EDUCATION

189. RELIGION

190. RACE

191. COLOR

192. SEX

193. AGE

194. DATE OF BIRTH

195. PLACE OF BIRTH

196. OCCUPATION

197. MARITAL STATUS

198. EDUCATION

199. RELIGION

200. RACE

201. COLOR

202. SEX

203. AGE

204. DATE OF BIRTH

205. PLACE OF BIRTH

206. OCCUPATION

207. MARITAL STATUS

208. EDUCATION

209. RELIGION

210. RACE

211. COLOR

212. SEX

213. AGE

214. DATE OF BIRTH

215. PLACE OF BIRTH

216. OCCUPATION

217. MARITAL STATUS

218. EDUCATION

219. RELIGION

220. RACE

221. COLOR

222. SEX

223. AGE

224. DATE OF BIRTH

225. PLACE OF BIRTH

226. OCCUPATION

227. MARITAL STATUS

228. EDUCATION

229. RELIGION

230. RACE

231. COLOR

232. SEX

233. AGE

234. DATE OF BIRTH

235. PLACE OF BIRTH

236. OCCUPATION

237. MARITAL STATUS

238. EDUCATION

239. RELIGION

240. RACE

241. COLOR

242. SEX

243. AGE

244. DATE OF BIRTH

245. PLACE OF BIRTH

246. OCCUPATION

247. MARITAL STATUS

248. EDUCATION

249. RELIGION

250. RACE

251. COLOR

252. SEX

253. AGE

254. DATE OF BIRTH

255. PLACE OF BIRTH

256. OCCUPATION

257. MARITAL STATUS

258. EDUCATION

259. RELIGION

10786

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. 10776

No. 116

<b>1. PLACE OF DEATH:</b> COUNTY <u>Dorchester</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Near Madis on</u> TOWN <u>Hunting</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>in Marsh</u>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> STATE <u>Maryland</u> COUNTY <u>Dorchester</u> CITY (If outside corporate limits write RURAL and give nearest town) <u>Church Creek,</u> TOWN <u>Church Creek,</u> STREET ADDRESS (If rural, give location) <u>1</u>	
---	--	--	--

<b>3. NAME OF DECEASED:</b> (First) (Middle) (Last) (Type or Print) <u>DARCY</u> <u>ANDREW</u> <u>HUGHES</u>			<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Nov.</u> <u>30</u> <u>1955</u>									
<b>5. SEX:</b> <u>M</u>	<b>6. COLOR OR RACE:</b> <u>W</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):</b> <u>S</u>	<b>8. DATE OF BIRTH:</b> <u>Feb. 16, 1937</u>	<b>9. AGE last birthday:</b> <u>18</u> yrs. <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;">IF UNDER 1 YEAR</td> <td style="width: 25%;">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> </table>	IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days	<b>10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):</b> <u>Waterman</u>	<b>10b. KIND OF BUSINESS OR INDUSTRY:</b> <u>Seafood</u>	<b>11. BIRTHPLACE (State or foreign country):</b> <u>Church Creek, Maryland</u>	<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>
IF UNDER 1 YEAR	IF UNDER 24 HRS.											
Months	Days											
<b>13. FATHER'S NAME:</b> <u>William A. Hughes</u>				<b>14. MOTHER'S MAIDEN NAME:</b> <u>Celia Fitzhugh</u>								
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)</b> <u>No</u>			<b>16. SOCIAL SECURITY No.:</b> 									
<b>17. INFORMANT &amp; ADDRESS:</b> <u>Parents Mrs. William Hughes Church Creek, Md.</u>												

<b>18. MEDICAL CERTIFICATION</b> <b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:</b> <u>799.8</u> Immediate cause (a) <u>Shot gun wound neck.</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)		INTERVAL BETWEEN ONSET AND DEATH
---	--	----------------------------------

<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>					
<b>19a. DATE OF OPERATION:</b> <u>0</u>		<b>19b. MAJOR FINDING OF OPERATION:</b>		<b>20. AUTOPSY?</b> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
<b>21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.</b>	<b>21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY in Marsh</b>	<b>21c. (City or town) (County) (State)</b> <u>Near Taylors Island, Dor. Md.</u>			
<b>21d. TIME (Month) (Day) (Year) (Hour) OF INJURY</b> <u>Nov. 30, 1955</u> <u>3</u> M.	<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/></b>	<b>21f. HOW DID INJURY OCCUR?</b> <u>Shot accidentally by hunting partner.</u>			

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE John M. [Signature] CHIEF MEDICAL EXAMINER ☐ DATE SIGNED Dec. 1, 1955  
 M. D. DEPUTY MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAM. ☐

<b>23. BURIAL, CREMATION, REMOVAL (Specify):</b> <u>Burial</u>	<b>DATE THEREOF</b> <u>Dec. 3, 1955</u>	<b>NAME OF CEMETERY OR CREMATORY</b> <u>Dorchester Memorial Park</u>	<b>LOCATION (City, town, or county) (State)</b> <u>Cambridge, Md.</u>
<b>DATE REC'D BY LOCAL REG.</b> <u>Dec. 1, 1955</u>		<b>REGISTRAR'S SIGNATURE</b> <u>John M. [Signature]</u>	
<b>24. FUNERAL DIRECTOR</b> <u>LeCompte Funeral Service</u>		<b>ADDRESS</b> <u>Cambridge, Md.</u>	

RECEIVED

DEC 5 1955

EAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10777  
10770 CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Dorchester</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Dorchester</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>13 TOWN Cambridge</b>		LENGTH OF STAY (in this place) <b>Life</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Cambridge</b> <b>13</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>67 Cambridge Md Hospital</b>				STREET ADDRESS (If rural give location) <b>Park Lane</b>			
3. NAME OF DECEASED: (First) (Middle) (Last) <b>Elizabeth Hughes</b>				4. DATE (Month) (Day) (Year) OF DEATH: <b>11 30 19 55</b>			
5. SEX: <b>Female</b>	6. COLOR OR RACE: <b>Negro</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <b>7-15-1884</b>	9. AGE last birthday <b>71</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unemployed</b>			10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <b>Dorchester-Co-Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME: <b>unknown</b>				14. MOTHER'S MAIDEN NAME: <b>Annie Morris</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>- - - -</b>	17. INFORMANT & ADDRESS: <b>Goldie Jackson-Park Lane-Camb.Md.</b>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <b>260X Diabetic Acidosis</b>							
ANTECEDENT CAUSE (B) <b>Diabetes Mellitus</b>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Nov. 30, 1955</b> to <b>Nov. 30, 1955</b> , that I last saw the deceased alive on <b>Nov. 30, 1955</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above. SIGNATURE <b>J. Edwin Fassett, M.D.</b> ADDRESS <b>227 Pine St-Camb., Md.</b> DATE SIGNED <b>12-3-55</b>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>12-4-55</b>	NAME OF CEMETERY OR CREMATORY <b>Vienna Cemetery</b>		LOCATION (City, town, or county) (State) <b>Vienna, Maryland</b>		
DATE REC'D BY LOCAL REGISTRAR <b>Dec. 4, 1955</b>		REGISTRAR'S SIGNATURE <b>[Signature]</b>		24. FUNERAL DIRECTOR ADDRESS <b>Herbert M. St. Clair, Jr., Cambridge, Md.</b>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 6 1955

BUREAU V. S.



## 10771 CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
13 TOWN <u>Cambridge</u>		entire life		13 TOWN <u>Cambridge</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
03 <u>Maryland Ave.</u>				<u>Maryland Ave.</u> (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Bessie</u>		(Middle) <u>Lyons</u>		(Last) <u>Johnson</u>		(Month) (Day) (Year)	
						NOV. 3, 1955	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female	White	Married	Dec. 6, 1904	50 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Womans Dress Shop Owner &amp; Operator</u>				<u>Cambridge</u>		<u>U.S.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Oscar P. Lyons</u>				<u>Nora M. Currey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
no		no		<u>Arthur Q. Johnson, Cambridge, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
170X IMMEDIATE CAUSE (A) <u>General Carcinomatosis</u>						1 yr.	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Adeno Carcinoma R. Breast</u>						7 yrs.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY?	
1948		<u>Adeno Carcinoma R. Breast</u>				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
		M.					
22. I hereby certify that I attended the deceased from <u>Jan</u> , 19 <u>50</u> , to <u>Nov. 3</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>NOV. 2</u> , 19 <u>55</u> , and that death occurred at <u>6 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>John Mouch</u>				ADDRESS (Street, city, town, state)		DATE SIGNED	
				<u>Cambridge, Maryland</u>		<u>Nov. 5, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>burial</u>		<u>Nov. 5, 1955</u>		<u>Dorchester Memorial Park</u>		<u>Cambridge, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Nov. 5, 1955</u>		<u>John Pace, R. D.</u>		<u>Benjamin R. Howard</u>		<u>Cambridge, Md.</u>	

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1977

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

## 1977 CERTIFICATE OF DEATH

Reg. Dist. No. 179

LOCAL RESIDENTS (HOUSE OF DECEASED)

PLACE OF DEATH

NAME OF DECEASED: **JOHN J. BURBAU**  
 SEX: **MALE**  
 RACE: **WHITE**  
 DATE OF BIRTH: **1915**  
 PLACE OF BIRTH: **NEW YORK**  
 MARRIED: **YES**  
 OCCUPATION: **RETIRED**  
 SOCIAL SECURITY NUMBER: **123-45-6789**  
 MARITAL STATUS: **MARRIED**  
 DECEASED'S ADDRESS: **1234 E. MAIN ST., BALTIMORE, MD 21201**  
 DECEASED'S PHONE: **555-1234**

DATE OF DEATH: **10/15/77**  
 PLACE OF DEATH: **HOME**  
 TIME OF DEATH: **10:00 AM**  
 CAUSE OF DEATH: **HEART DISEASE**  
 MANNER OF DEATH: **NATURAL**

DECEASED'S AGE: **62**  
 DECEASED'S SEX: **MALE**  
 DECEASED'S RACE: **WHITE**  
 DECEASED'S DATE OF BIRTH: **1915**  
 DECEASED'S PLACE OF BIRTH: **NEW YORK**

DECEASED'S MARRIED: **YES**  
 DECEASED'S OCCUPATION: **RETIRED**  
 DECEASED'S SOCIAL SECURITY NUMBER: **123-45-6789**  
 DECEASED'S MARITAL STATUS: **MARRIED**

DECEASED'S ADDRESS: **1234 E. MAIN ST., BALTIMORE, MD 21201**  
 DECEASED'S PHONE: **555-1234**  
 DECEASED'S DATE OF DEATH: **10/15/77**  
 DECEASED'S PLACE OF DEATH: **HOME**

DECEASED'S TIME OF DEATH: **10:00 AM
 DECEASED'S CAUSE OF DEATH: **HEART DISEASE**  
 DECEASED'S MANNER OF DEATH: **NATURAL****

DECEASED'S AGE: **62**  
 DECEASED'S SEX: **MALE**  
 DECEASED'S RACE: **WHITE**  
 DECEASED'S DATE OF BIRTH: **1915**  
 DECEASED'S PLACE OF BIRTH: **NEW YORK**

DECEASED'S MARRIED: **YES**  
 DECEASED'S OCCUPATION: **RETIRED**  
 DECEASED'S SOCIAL SECURITY NUMBER: **123-45-6789**  
 DECEASED'S MARITAL STATUS: **MARRIED**

DECEASED'S ADDRESS: **1234 E. MAIN ST., BALTIMORE, MD 21201**  
 DECEASED'S PHONE: **555-1234**  
 DECEASED'S DATE OF DEATH: **10/15/77**  
 DECEASED'S PLACE OF DEATH: **HOME**

DECEASED'S TIME OF DEATH: **10:00 AM**  
 DECEASED'S CAUSE OF DEATH: **HEART DISEASE**  
 DECEASED'S MANNER OF DEATH: **NATURAL**

DECEASED'S AGE: **62**  
 DECEASED'S SEX: **MALE**  
 DECEASED'S RACE: **WHITE**  
 DECEASED'S DATE OF BIRTH: **1915**  
 DECEASED'S PLACE OF BIRTH: **NEW YORK**

DECEASED'S MARRIED: **YES**  
 DECEASED'S OCCUPATION: **RETIRED**  
 DECEASED'S SOCIAL SECURITY NUMBER: **123-45-6789**  
 DECEASED'S MARITAL STATUS: **MARRIED**

DECEASED'S ADDRESS: **1234 E. MAIN ST., BALTIMORE, MD 21201**  
 DECEASED'S PHONE: **555-1234**  
 DECEASED'S DATE OF DEATH: **10/15/77**  
 DECEASED'S PLACE OF DEATH: **HOME**

DECEASED'S TIME OF DEATH: **10:00 AM**  
 DECEASED'S CAUSE OF DEATH: **HEART DISEASE**  
 DECEASED'S MANNER OF DEATH: **NATURAL**

DECEASED'S AGE: **62**  
 DECEASED'S SEX: **MALE**  
 DECEASED'S RACE: **WHITE**  
 DECEASED'S DATE OF BIRTH: **1915**  
 DECEASED'S PLACE OF BIRTH: **NEW YORK**

DECEASED'S MARRIED: **YES**  
 DECEASED'S OCCUPATION: **RETIRED**  
 DECEASED'S SOCIAL SECURITY NUMBER: **123-45-6789**  
 DECEASED'S MARITAL STATUS: **MARRIED**

1. This certificate is to be filled out by the physician or other qualified person who attended the deceased during his or her last illness. It should be filled out as soon as possible after death, but not later than 72 hours after death. It should be signed by the physician or other qualified person who attended the deceased during his or her last illness. It should be filed with the local health department or other authority having jurisdiction over vital statistics. It should be retained for a period of 10 years.

RECEIVED

J. H. BURBAU

10772

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

10779

Reg. Dist. No. 116

<b>1. PLACE OF DEATH:</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b>			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Dor.</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Cambridge</u>				TOWN <u>Cambridge</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pine Street</u>				STREET ADDRESS (If rural, give location) <u>Fairmount Avenue</u>			
<b>3. NAME OF DECEASED:</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Mahalia</u> -- <u>Johnson</u>				<u>Nov.</u> <u>24</u> 19 <u>55</u>			
<b>5. SEX:</b>	<b>6. COLOR OR RACE:</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):</b>	<b>8. DATE OF BIRTH:</b>	<b>9. AGE last birthday:</b>	<b>IF UNDER 1 YEAR</b> (Months) (Days) (Hours) (Min.)		
<u>Female</u>	<u>Negro</u>	<u>W.</u>	<u>May 20, 1899</u>	<u>56</u> yrs.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of work life, even if retired): <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY:</b>		<b>11. BIRTHPLACE</b> (State or foreign country): <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME:</b> <u>William Schofield</u>				<b>14. MOTHER'S MAIDEN NAME:</b> <u>Pinkie Laws</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY No.:</b>		<b>17. INFORMANT &amp; ADDRESS:</b> <u>James Ennals, Cambridge, Maryland</u>			

<b>18. MEDICAL CERTIFICATION</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:</b>					
<u>420.1</u> (a) <u>Coronary Occlusion</u>					
Immediate cause DUE TO					
Antecedent cause(s) (b)					
Diseases or conditions, if any, giving rise to the above cause DUE TO					
stating underlying cause last (c)					
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>					
<b>19a. DATE OF OPERATION:</b>		<b>19b. MAJOR FINDING OF OPERATION:</b>		<b>20. AUTOPSY?</b> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
<u>0</u>					
<b>21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b>		<b>21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY</b>		<b>21c. (City or town) (County) (State)</b>	
<b>21d. TIME (Month) (Day) (Year) (Hour) OF INJURY</b>		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>	
<b>22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</b>					
SIGNATURE <u>John Mace</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>11-28-55</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/>			
<b>23. BURIAL, CREMATION, REMOVAL (Specify):</b> <u>Burial</u>		<b>DATE THEREOF:</b> <u>11-29-55</u>		<b>NAME OF CEMETERY OR CREMATORY:</b> <u>Bethel Cemetery</u>	
				<b>LOCATION (City, town, or county) (State):</b> <u>Cambridge, Maryland</u>	
<b>DATE REC'D BY LOCAL REG.</b> <u>11-28-55</u>		<b>REGISTRAR'S SIGNATURE:</b> <u>John Mace, M. D.</u>		<b>24. FUNERAL DIRECTOR ADDRESS:</b> <u>Herbert St. Clair, Cambridge, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 5 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10780

10773

## CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Dorchester</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Dorchester</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>13 TOWN Cambridge</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <b>OR TOWN Cambridge</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>616 High St</b>				STREET ADDRESS (If rural give location) <b>616 High St</b>			
3. NAME OF DECEASED: (First) (Middle) (Last) <b>George W. Jones</b>				4. DATE (Month) (Day) (Year) OF DEATH: <b>11 28 19 55</b>			
5. SEX: <b>Male</b>	6. COLOR OR RACE: <b>Negro</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Widowed</b>	8. DATE OF BIRTH:	9. AGE last birthday <b>Approx. 68</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>unemployed</b>			10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <b>Dorchester-Co-Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME: <b>George Lyte</b>				14. MOTHER'S MAIDEN NAME: <b>Henrietta Jones</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) (If Yes, give war or dates of service) <b>2 Yes WW I</b>		16. SOCIAL SECURITY NO. <b>unk</b>		17. INFORMANT & ADDRESS: <b>Ernest Lyte-Cambridge, Md.</b>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <b>Cardiac Decompensation</b>							
ANTECEDENT CAUSE (B) <b>Hypertensive Arteriosclerotic heart disease</b>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>June 19 55</b> to <b>Nov 28 19 55</b> , that I last saw the deceased alive on <b>19 55</b> and that death occurred at <b>M</b> , from the causes and on the date stated above. SIGNATURE <b>Edwin Fassett</b> ADDRESS <b>227 Pine St-Camb., Md.</b> DATE SIGNED <b>12-3-55</b>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>12-2-55</b>		NAME OF CEMETERY OR CREMATORY <b>Bethel Cemetery</b>		LOCATION (City, town, or county) (State) <b>Cambridge, Md.</b>	
DATE REC'D BY LOCAL REGISTRAR <b>Dec. 2, 1955</b>		REGISTRAR'S SIGNATURE <b>J. H. ...</b>		24. FUNERAL DIRECTOR <b>H.M. StClair, Jr.</b>		ADDRESS <b>High St-Camb., Md.</b>	

BUREAU V. 1

DEC 6 1955

RECEIVED

VALLEY'S  
CONGRESS  
BOND



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10781

10774 **CERTIFICATE OF DEATH**Reg. Dist. No. 116

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Dorchester</u>		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
13 TOWN <u>Cambridge</u>		<u>entire life</u>		13 TOWN <u>Cambridge</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
00 <u>104 Aurora St.</u>				<u>104 Aurora St.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
(First) <u>Ernest</u>		(Middle) <u>Henry</u>		(Last) <u>Leap</u>		<u>Nov. 7, 1955</u> 19	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>July 10, 1900</u>	<u>55</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Meter Reader for Electric Co.</u>				<u>Cambridge</u>		<u>U.S.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>A. Arthur Leap</u>				<u>Bernice Lamm</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>NO</u>		<u>NO</u>		<u>104 Aurora St.</u>			
		<u>214-07-7166</u>		<u>Mrs. Katherine W. Leap, Cambridge, Md.</u>			
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
1 DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						<u>420.1</u>	
IMMEDIATE CAUSE (A) <u>Coronary thrombosis</u>						<u>immediately</u>	
ANTECEDENT CAUSE(S) DUE TO <u>Coronary Heart Disease</u>						<u>3 mos.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>Hypertensive Cardio Vascular Disease</u>						<u>5 yrs.</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
<u>0</u>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3/27</u> <u>7:00 P.M.</u> to <u>11/7</u> <u>1955</u> , that I last saw the deceased alive on <u>11/6</u> <u>1955</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Robert E. Bunker</u>				ADDRESS (Street, city, town, state) <u>M.D. 9 Race St., Cambridge, Maryland</u>			
				DATE SIGNED <u>11-9-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>burial</u>		<u>Nov. 9, 1955</u>		<u>Dorchester Memorial Park</u>		<u>Cambridge, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Nov 9 1955</u>		<u>John Race, R. D.</u>		<u>Kenneth R. Brown</u>		<u>Cambridge, Md.</u>	

10521

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

# 10521 CERTIFICATE OF DEATH

REG. CHG. NO.

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

AGE

RACE

RELIGION

EDUCATION

OCCUPATION

STATUS

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SEX

AGE

RACE

RELIGION

EDUCATION

OCCUPATION

STATUS

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SEX

AGE

RACE

RELIGION

EDUCATION

OCCUPATION

STATUS

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SEX

AGE

RACE

RELIGION

EDUCATION

OCCUPATION

STATUS

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SEX

AGE

RACE

RELIGION

EDUCATION

OCCUPATION

STATUS

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SEX

AGE

RACE

RELIGION

EDUCATION

OCCUPATION

STATUS

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SEX

AGE

RACE

RELIGION

EDUCATION

OCCUPATION

STATUS

BUREAU V. S.

NOV 21 1955

RECEIVED

*Handwritten signature*

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10787

## CERTIFICATE OF DEATH

10782

Reg. Dist. No. 116

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL or end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Hurlock</u>		<u>15 yrs</u>		TOWN <u>Hurlock, Md.</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>Andrews and Railroad Ave</u>				<u>Andrews &amp; Railroad Ave.</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Nola Glander Lidden</u>				<u>11 2 19 55</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b> yrs.	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
<u>F</u>	<u>W</u>	<u>Married</u>	<u>1/17/1891</u>	<u>64</u>	Months	Days	Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)			<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>
<u>Laborer</u>			<u>Food Canning</u>		<u>Queens Ann County</u>		<u>USA</u>
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>James Glander</u>				<u>Rebecca Everett</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<u>No</u>				<u>Mr Jesse Lidden Hurlock Md.</u>			
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
<u>420.0</u> IMMEDIATE CAUSE (A) <u>Acute Coronary Occlusion</u>						<u>6 hours</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Heart Disease</u>						<u>370.5</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Generalized Arteriosclerosis</u>						<u>10 yrs</u>	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>11/2</u>, 19<u>55</u>, to <u>11/2</u>, 19<u>55</u>, that I last saw the deceased alive on <u>11/2</u>, 19<u>55</u>, and that death occurred at <u>4:20 P.M.</u> from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>				<b>ADDRESS</b> (Street, city, town, state)		<b>DATE SIGNED</b>	
<u>John H. Plummer</u> M.D.				<u>Parson Ray</u>		<u>11/4/55</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION</b> (City, town, or county) (State)	
<u>Burial</u>		<u>11/6/ 55</u>		<u>Washington Cemetery</u>		<u>Dorchester County Md</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
DATE <u>Nov 6, 1955</u>		<u>John H. Plummer, M.D.</u>		<u>Le Compte Funeral Service</u>			

# CERTIFICATE OF DEATH

10-10-1961

10-10-1961

1. NAME OF DECEASED

2. SEX

3. DATE OF BIRTH

4. PLACE OF BIRTH

5. OCCUPATION

6. MARITAL STATUS

7. RACE

8. EDUCATION

9. PREVIOUS ILLNESS

10. CAUSE OF DEATH

11. PLACE OF DEATH

12. TIME OF DEATH

13. SIGNATURE OF PHYSICIAN

14. SIGNATURE OF REGISTRAR

15. SIGNATURE OF WITNESSES

16. SIGNATURE OF DECEASED

17. SIGNATURE OF FUNERAL HOME

18. SIGNATURE OF CHURCH

19. SIGNATURE OF BURIAL PLACE

20. SIGNATURE OF OTHER

21. SIGNATURE OF

22. SIGNATURE OF

23. SIGNATURE OF

24. SIGNATURE OF

25. SIGNATURE OF

26. SIGNATURE OF

27. SIGNATURE OF

28. SIGNATURE OF

29. SIGNATURE OF

30. SIGNATURE OF

31. SIGNATURE OF

32. SIGNATURE OF

33. SIGNATURE OF

34. SIGNATURE OF

35. SIGNATURE OF

36. SIGNATURE OF

37. SIGNATURE OF

38. SIGNATURE OF

39. SIGNATURE OF

40. SIGNATURE OF

41. SIGNATURE OF

42. SIGNATURE OF

43. SIGNATURE OF

44. SIGNATURE OF

45. SIGNATURE OF

46. SIGNATURE OF

47. SIGNATURE OF

48. SIGNATURE OF

49. SIGNATURE OF

50. SIGNATURE OF

51. SIGNATURE OF

52. SIGNATURE OF

53. SIGNATURE OF

54. SIGNATURE OF

55. SIGNATURE OF

56. SIGNATURE OF

57. SIGNATURE OF

58. SIGNATURE OF

59. SIGNATURE OF

60. SIGNATURE OF

61. SIGNATURE OF

62. SIGNATURE OF

63. SIGNATURE OF

64. SIGNATURE OF

65. SIGNATURE OF

66. SIGNATURE OF

67. SIGNATURE OF

68. SIGNATURE OF

69. SIGNATURE OF

70. SIGNATURE OF

71. SIGNATURE OF

72. SIGNATURE OF

73. SIGNATURE OF

74. SIGNATURE OF

75. SIGNATURE OF

76. SIGNATURE OF

77. SIGNATURE OF

78. SIGNATURE OF

79. SIGNATURE OF

80. SIGNATURE OF

81. SIGNATURE OF

82. SIGNATURE OF

83. SIGNATURE OF

84. SIGNATURE OF

85. SIGNATURE OF

86. SIGNATURE OF

87. SIGNATURE OF

88. SIGNATURE OF

89. SIGNATURE OF

90. SIGNATURE OF

91. SIGNATURE OF

92. SIGNATURE OF

93. SIGNATURE OF

94. SIGNATURE OF

95. SIGNATURE OF

96. SIGNATURE OF

97. SIGNATURE OF

98. SIGNATURE OF

99. SIGNATURE OF

100. SIGNATURE OF

101. SIGNATURE OF

102. SIGNATURE OF

103. SIGNATURE OF

104. SIGNATURE OF

105. SIGNATURE OF

106. SIGNATURE OF

107. SIGNATURE OF

108. SIGNATURE OF

109. SIGNATURE OF

110. SIGNATURE OF

111. SIGNATURE OF

112. SIGNATURE OF

113. SIGNATURE OF

114. SIGNATURE OF

115. SIGNATURE OF

116. SIGNATURE OF

117. SIGNATURE OF

118. SIGNATURE OF

119. SIGNATURE OF

120. SIGNATURE OF

121. SIGNATURE OF

122. SIGNATURE OF

123. SIGNATURE OF

124. SIGNATURE OF

125. SIGNATURE OF

126. SIGNATURE OF

127. SIGNATURE OF

128. SIGNATURE OF

129. SIGNATURE OF

130. SIGNATURE OF

131. SIGNATURE OF

132. SIGNATURE OF

133. SIGNATURE OF

134. SIGNATURE OF

135. SIGNATURE OF

136. SIGNATURE OF

137. SIGNATURE OF

138. SIGNATURE OF

139. SIGNATURE OF

140. SIGNATURE OF

NOTIFICATION

NOTIFICATION OF DEATH TO NEAREST RELATIVE OF DECEASED  
 The undersigned, Registrar of the State Department of Health, Baltimore, Maryland, hereby certifies that the above named deceased person has died at the place and on the date stated above, and that the cause of death is as stated above. This certificate is being furnished to you for your information and for the purpose of notifying you of the death of your relative. It is not to be used as evidence of death in any court of law.

BUREAU V.S.

NOV 8 1961

REGISTERED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10788

## CERTIFICATE OF DEATH

Reg. Dist. No.

10783

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Dorchester</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Dorchester</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
<u>X</u> TOWN <u>rural Cambridge</u>		TOWN <u>Cambridge</u>	<u>13</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Eastern Shore State Hospital</u>		STREET ADDRESS (If rural give location) <u>1</u>	
3. NAME OF DECEASED: (First) <u>Annie</u> (Middle) (Last) <u>Mowbray</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Nov 27 1955</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>wid</u>	8. DATE OF BIRTH: <u>3-15-1871</u>
		9. AGE last birthday: <u>84</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Homf-</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Not known</u>		14. MOTHER'S MAIDEN NAME: <u>Not known</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>If no</u> (If Yes, give war or dates of service)		15. SOCIAL SECURITY NO. <u>920</u>	
16. INFORMANT & ADDRESS:			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
331X IMMEDIATE CAUSE (A) <u>Cerebral Haemorrhage</u>		<u>5 days</u>	
ANTECEDENT CAUSE (S) (B) <u>Cerebral Arteriosclerosis</u>		<u>2 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Mar 3, 1955</u> , to <u>Nov 27, 1955</u> , that I last saw the deceased alive on <u>Nov 27, 1955</u> , and that death occurred at <u>3:30 P.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Thomas J. Dudge</u>		DATE SIGNED <u>11-27-55</u>	
ADDRESS <u>M. D. Cambridge Md</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11/29/55</u>	
NAME OF CEMETERY OR CREMATORY <u>East New Market Cem.</u>		LOCATION (City, town, or county) (State) <u>East New Market Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Nov 29, 1955</u>		REGISTRAR'S SIGNATURE <u>John H. Lee</u>	
24. FUNERAL DIRECTOR <u>LeCompte Funeral Service</u>		ADDRESS <u>Cambridge Md.</u>	

RECEIVED

DEC 2 1955

BUREAU V. S.



10789

10784  
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 116

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Caroline</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Cambridge</u>		LENGTH OF STAY (in this place) <u>12 yrs. 3 months</u>		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Greensboro, Maryland</u>		<u>05X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Eastern Shore State Hospital</u>				STREET ADDRESS (If rural, give location) ---			
3. NAME OF DECEASED: (First) <u>William</u> (Middle) <u>(Monk)</u> (Last) <u>Murphy</u>		4. DATE OF DEATH <u>Nov.</u> <u>18</u> <u>19 55</u>					
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>April 9, 1890</u>	9. AGE last birthday: <u>65</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>---</u>		11. BIRTHPLACE (State or foreign country): <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>John Hitchens</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Davis</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>---</u>		16. SOCIAL SECURITY No.: <u>---</u>		17. INFORMANT & ADDRESS: <u>Eastern Shore State Hospital Records</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						5 Min.	
<u>430.1</u> Immediate cause (a) <u>Coronary Occlusion</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO <u>260.1</u> stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: <u>Diabetes Mellitus</u>						?	
19a. DATE OF OPERATION: <u>0</u>		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>James M. Murphy</u>		M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/>		DATE SIGNED <u>11/18/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Removal</u>		DATE THEREOF <u>11-21-55</u>		NAME OF CEMETERY OR CREMATORY <u>Anatomical Bld</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
DATE REC'D BY LOCAL REG. <u>Nov. 21, 1955</u>		REGISTRAR'S SIGNATURE <u>John M. Murphy, R. D.</u>		24. FUNERAL DIRECTOR <u>Brookman West</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

NOV -23 1956

RECEIVED

10790

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. No. 10785

No. 116

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Dorchester</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR			
TOWN <u>Hoopersville</u>		<u>lifetime</u>		TOWN <u>Hoopersville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>White &amp; Nelson Factory</u>				STREET ADDRESS (If rural, give location) <u>1</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
OSCAR WITTINGTON NELSON				Nov. 21 1955			
5. SEX: M	6. COLOR OR RACE: W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): M	8. DATE OF BIRTH: August 14, 1887	9. AGE last birthday: 68 yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Seafood Packer</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Seafood</u>		11. BIRTHPLACE (State or foreign country): <u>Hoopersville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Edmund Nelson</u>				14. MOTHER'S MAIDEN NAME: <u>Sadie Lewis</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>218-34-9633</u>		17. INFORMANT & ADDRESS: <u>Oscar W. Nelson Jr. Cambridge, Md.</u>			

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				Instant	
<p>4201</p> <p>Immediate cause (a) <u>Coronary Occlusion</u></p> <p style="text-align: center;">DUE TO</p> <p>Antecedent cause(s) (b) _____</p> <p>Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) _____</p>					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION: <u>0</u>		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY)		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
<p>22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</p> <p>SIGNATURE <u>[Signature]</u> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/></p> <p style="text-align: right;">DATE SIGNED <u>Nov. 28 1955</u></p>					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>11/23/55</u>		NAME OF CEMETERY OR CREMATORY <u>Dorchester Memorial Park</u>	
DATE REC'D BY LOCAL REG. <u>Nov. 23, 1955</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>LECOMPTE FUNERAL SERVICE</u> ADDRESS <u>CAMBRIDGE, MD.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

NOV 29 1955

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10786

## 10791 CERTIFICATE OF DEATH

Reg. Dist. No. 110

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Williamsburg</u>		<u>Life</u>		TOWN <u>Williamsburg</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
00				1			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Edith</u> <u>Poole</u>				<u>November 22</u> <u>19</u> <u>55</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>August 6, 1872</u>	<u>83</u> yrs.	Months	Days	Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>Housework</u>		<u>Home</u>		<u>Dorchester Co., Maryland</u>		<u>U.S.A.</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>Thomas R. Rowins</u>				<u>Margaret E. Wright</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<u>4 NO</u>		<u>None</u>		<u>Kelso L. Poole, Hurlock, Md., R.F.D.</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>420.0 IMMEDIATE CAUSE</b> (A) <u>Bronch. pneumonia</u>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>ANTECEDENT CAUSE(S) DUE TO</b> (B) <u>Chronic Congestive Heart Failure</u>						<u>3 days</u>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b> (C) <u>Arteriosclerotic Heart Disease</u>						<u>5 years</u>	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>						<u>15 years</u>	
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b>		<b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>	
<u>8</u>		<u>-</u>		<u>-</u>		<u>-</u>	
<b>21a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>21b. PLACE</b> (Home, farm, factory, OF INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<u>-</u>		<u>-</u>		<u>-</u>			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<u>-</u>		<u>-</u>		<u>-</u>			
<b>22. I hereby certify that I attended the deceased from</b> <u>3:24</u> , <u>19</u> <u>45</u> , <u>to</u> <u>11/22</u> , <u>19</u> <u>55</u> , <u>that I last saw the deceased</u> <u>alive on</u> <u>11/22</u> , <u>19</u> <u>55</u> , <u>and that death occurred at</u> <u>7:15P.M.</u> , <u>from the causes and on the date stated above.</u>							
<b>SIGNATURE</b> <u>[Signature]</u> <b>M.D.</b>				<b>ADDRESS</b> (Street, city, town, state) <b>DATE SIGNED</b>			
<u>Preston, Maryland</u>							
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION</b> (City, town, or county) (State)	
<u>Burial</u>		<u>Nov. 26, 1955</u>		<u>Washington Cemetery</u>		<u>Hurlock, Maryland</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>ADDRESS</b>			
<u>Nov 26-1955</u>		<u>[Signature]</u>		<u>J.J. Frampton and Son, Federalsburg, Md.</u>			

# 1078 CERTIFICATE OF DEATH

ALABAMA STATE DEPARTMENT OF HEALTH - BIRMINGHAM 10

1078

Form 10-1-44

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. AGE

5. DATE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF REGISTRAR

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF CORONER

13. SIGNATURE OF JURY

14. SIGNATURE OF JUDGE

15. SIGNATURE OF CLERK

16. SIGNATURE OF SHERIFF

17. SIGNATURE OF DEPUTY SHERIFF

18. SIGNATURE OF CONSTABLE

19. SIGNATURE OF JURY

20. SIGNATURE OF JUDGE

21. SIGNATURE OF CLERK

22. SIGNATURE OF SHERIFF

23. SIGNATURE OF DEPUTY SHERIFF

24. SIGNATURE OF CONSTABLE

25. SIGNATURE OF JURY

26. SIGNATURE OF JUDGE

27. SIGNATURE OF CLERK

28. SIGNATURE OF SHERIFF

29. SIGNATURE OF DEPUTY SHERIFF

30. SIGNATURE OF CONSTABLE

31. SIGNATURE OF JURY

32. SIGNATURE OF JUDGE

33. SIGNATURE OF CLERK

34. SIGNATURE OF SHERIFF

35. SIGNATURE OF DEPUTY SHERIFF

36. SIGNATURE OF CONSTABLE

37. SIGNATURE OF JURY

38. SIGNATURE OF JUDGE

39. SIGNATURE OF CLERK

39. SIGNATURE OF SHERIFF

40. SIGNATURE OF DEPUTY SHERIFF

41. SIGNATURE OF CONSTABLE

42. SIGNATURE OF JURY

43. SIGNATURE OF JUDGE

44. SIGNATURE OF CLERK

45. SIGNATURE OF SHERIFF

46. SIGNATURE OF DEPUTY SHERIFF

47. SIGNATURE OF CONSTABLE

48. SIGNATURE OF JURY

49. SIGNATURE OF JUDGE

50. SIGNATURE OF CLERK

51. SIGNATURE OF SHERIFF

52. SIGNATURE OF DEPUTY SHERIFF

53. SIGNATURE OF CONSTABLE

54. SIGNATURE OF JURY

55. SIGNATURE OF JUDGE

56. SIGNATURE OF CLERK

BUREAU V. S.

DEC 5 1935

RECEIVED

RECEIVED



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 10775 CERTIFICATE OF DEATH

10787

Reg. Dist. No. 116

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>13</u> TOWN <u>Cambridge</u>		LENGTH OF STAY (in this place) <u>13</u> <u>Life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cambridge</u>		<u>13</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>67</u> <u>Cambridge Md Hospital</u>				STREET ADDRESS (If rural give location) <u>1</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) (First) (Middle) (Last) <u>Baby</u> <u>Girl</u> <u>Rhodes</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>November</u> <u>14</u> <u>1955</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>11-7-55</u>	9. AGE last birthday yrs. <u>7</u>	IF UNDER 1 YEAR Months <u>7</u>		IF UNDER 24 HRS. Hours <u>7</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) - - - - -		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) <u>Dorchester-Co-Md.</u>		12. CITIZEN OF WHAT COUNTRY? - - - - -	
13. FATHER'S NAME <u>Earl Rhodes</u>				14. MOTHER'S MAIDEN NAME <u>Mattie Corinthian Brooks</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) - - - - -		16. SOCIAL SECURITY NO. - - - - -		17. INFORMANT & ADDRESS - - - - -			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
IMMEDIATE CAUSE (A) <u>774 X</u> <u>premature Ateliosis</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE</u>							
STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>UNDERLYING CAUSE LAST.</u>							
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION <u>Nov 12, 1955</u>		19b. MAJOR FINDINGS OF OPERATION - - - - -		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? - - - - -			
<b>22. I hereby certify that I attended the deceased from <u>Nov 7, 1955</u>, to <u>Nov 12, 1955</u>, that I last saw the deceased alive on <u>Nov 12, 1955</u>, and that death occurred at <u>11:15 AM</u>, from the causes and on the date stated above.</b>							
SIGNATURE <u>J. Edwin Fassett</u>				ADDRESS (Street, city, town, state) <u>227 Pine St-Camb., Md.</u>			
DATE SIGNED <u>Nov 15, 1955</u>				DATE SIGNED <u>Nov 15, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>11/15/1955</u>		NAME OF CEMETERY OR CREMATORY <u>Waugh Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cambridge, Maryland</u>	
24. REC'D BY REGISTRAR <u>John Moore, M.D.</u>		REGISTRAR'S SIGNATURE <u>John Moore, M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. M. S. S. S.</u>		ADDRESS <u>Cambridge, Md.</u>	

21X53633-1

# 1075 CERTIFICATE OF DEATH

1. Usual Residence (Home or Business)

2. Date of Death

3. Place of Death

4. Name of Physician

5. Name of Hospital

6. Name of Nurse

7. Name of Undertaker

8. Name of Coroner

9. Name of Medical Examiner

10. Name of Pathologist

11. Name of Anatomist

12. Name of Embalmer

13. Name of Burial Place

14. Name of Cemetery

15. Name of Interment

16. Name of Burial

17. Name of Burial

18. Name of Burial

19. Name of Burial

20. Name of Burial

21. Name of Burial

22. Name of Burial

23. Name of Burial

24. Name of Burial

25. Name of Burial

26. Name of Burial

27. Name of Burial

28. Name of Burial

29. Name of Burial

30. Name of Burial

31. Name of Burial

32. Name of Burial

33. Name of Burial

34. Name of Burial

35. Name of Burial

36. Name of Burial

37. Name of Burial

38. Name of Burial

39. Name of Burial

40. Name of Burial

41. Name of Burial

42. Name of Burial

43. Name of Burial

44. Name of Burial

45. Name of Burial

46. Name of Burial

47. Name of Burial

48. Name of Burial

49. Name of Burial

50. Name of Burial

51. Name of Burial

52. Name of Burial

53. Name of Burial

54. Name of Burial

55. Name of Burial

56. Name of Burial

57. Name of Burial

58. Name of Burial

59. Name of Burial

60. Name of Burial

61. Name of Burial

62. Name of Burial

63. Name of Burial

64. Name of Burial

65. Name of Burial

66. Name of Burial

67. Name of Burial

68. Name of Burial

69. Name of Burial

70. Name of Burial

BUREAU V. 2

NOV 18 1935

RECEIVED

*Handwritten signature*

RECEIVED

NOV 18 1935

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 10776 CERTIFICATE OF DEATH

10788

Reg. Dist. No. 116

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cambridge</u>		<u>life</u>		TOWN <u>Cambridge</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cambridge Md. Hosp</u>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Baby Girl Rhodes</u>				<u>11 8 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
<u>Female</u>	<u>Negro</u>	<u>single</u>	<u>11-7-55</u>		<u>1</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
				<u>Dorchester-Co-Md.</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Earl Rhodes</u>				<u>Mattie Corinthian Brooks</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>9 - - - - -</u>		<u>- - - - -</u>					
<b>1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<u>762.5</u> IMMEDIATE CAUSE (A) <u>Premature Atelectasis</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<u>0</u>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from <u>Nov 7</u>, 19<u>55</u>, to <u>Nov 8</u>, 19<u>55</u>, that I last saw the deceased alive on <u>Nov 8</u>, 19<u>55</u>, and that death occurred at <u>1:20 PM</u>, from the causes and on the date stated above.</b>							
SIGNATURE <u>J. Edwin Fassett</u>				ADDRESS (Street, city, town, state) <u>227 Pine St-Cambridge, Md.</u>			
DATE THEREOF <u>11/8/1955</u>				DATE SIGNED <u>11-12-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)		(State)	
<u>Burial</u>		<u>Waugh Cemetery</u>		<u>Cambridge, Maryland</u>			
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Nov. 8, 1955</u>		<u>J. H. H. D.</u>		<u>J. H. H. D.</u>		<u>Cambridge, Maryland</u>	

21X537232



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10792

## CERTIFICATE OF DEATH

10789

Reg. Dist. No. 115

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Dorchester</u>		STATE <u>Maryland</u> COUNTY <u>Dorchester</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Fishing Creek</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Fishing Creek</u>	
OR TOWN <u>Fishing Creek</u>		LENGTH OF STAY (in this place) <u>Lifetime</u>		OR TOWN <u>Fishing Creek</u>		STREET ADDRESS (If rural give location) <u>at home of Mr. Ronald McGloughlin</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mr. Ronald McGloughlin</u>				STREET ADDRESS (If rural give location) <u>1</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
(First) <u>Gorman</u> (Middle) <u>Robinson</u> (Last) <u>Robinson</u>				Nov. 15 1955			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u>	8. DATE OF BIRTH <u>October 22, 1893</u>	9. AGE last birthday <u>62</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Post Master</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>	11. BIRTHPLACE (State or foreign country) <u>Dorchester Co. Md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Frank Robinson</u>				14. MOTHER'S MAIDEN NAME <u>Callina Parks</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service) <u>World War 1</u>				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mr. Ronald McGloughlin</u>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
IMMEDIATE CAUSE (A) <u>442x Cardio-renal-vascular disease</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>with Hypertension and Cerebral hemorrhage</u>						10 yrs.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>none</u>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>Md.</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from Dec. 1945, to Nov. 1955, that I last saw the deceased alive on Nov. 15, 1955, and that death occurred at 11 P.M. from the causes and on the date stated above.</b>							
SIGNATURE <u>James W. Meade</u> M.D. <u>Fishing Creek, Md.</u>				ADDRESS <u>Street, city, town, state</u> <u>Nov 17, 1955</u> DATE SIGNED			
23. BURIAL, CREMATION REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11/18/55</u>		NAME OF CEMETERY OR CREMATORY <u>Dorchester Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Cambridge, Md.</u>	
24. REC'D BY REGISTRAR <u>Nov. 17/55</u>		REGISTRAR'S SIGNATURE <u>James W. Meade</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>LECOMPT FURNAL SERVICE</u>		ADDRESS <u>Cambridge, Md.</u>	



# CERTIFICATE OF DEATH

BUREAU V. 2

NOV 23 1955

RECEIVED

DECLARATION

TO THE PUBLIC HEALTH OFFICE, BALTIMORE, MARYLAND, FOR THE PURPOSE OF OBTAINING A DEATH CERTIFICATE, I HEREBY CERTIFY THAT THE DECEASED WAS A RESIDENT OF THIS STATE AT THE TIME OF HIS OR HER DEATH, AND THAT THE DEATH WAS CAUSED BY THE DISEASE OR INJURY SPECIFIED HEREON, AND THAT THE DEATH WAS NOT CAUSED BY A DISEASE OR INJURY WHICH IS REPORTABLE TO THE HEALTH DEPARTMENT OF THIS STATE.



10793  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. **10790**

No. **116**

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Dorchester</b>		MARYLAND		STATE <b>Maryland</b> COUNTY <b>Dorchester</b>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>Toddville</b>		LENGTH OF STAY (in this place) <b>12 Yr.</b>		CITY (If outside corporate limits write RURAL and give nearest town) OR <b>Toddville</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>in oyster boat</b>				STREET ADDRESS (If rural, give location) <b>1</b>			
3. NAME OF DECEASED: (First) <b>ALVIN</b>		(Middle) <b>JOHN</b>		(Last) <b>ROSE</b>		4. DATE OF DEATH (Month) <b>11</b> (Day) <b>17</b> (Year) <b>1955</b>	
5. SEX: <b>M</b>	6. COLOR OR RACE: <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>M</b>	8. DATE OF BIRTH: <b>10/15/99</b>		9. AGE last birthday: <b>56</b> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <b>waterman</b>		10b. KIND OF BUSINESS OR INDUSTRY: <b>seafood</b>		11. BIRTHPLACE (State or foreign country): <b>Scranton, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME: <b>Charles L. Rose</b>				14. MOTHER'S MAIDEN NAME: <b>Annie Vicinus</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>no</b>		16. SOCIAL SECURITY No.: (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: <b>Mrs. Alvin Rose Bishops Head, Md.</b>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: <b>420.1</b> Immediate cause (a)..... <b>Coronary Occlusion</b> DUE TO Antecedent cause(s) (b)..... Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c) II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						<b>Instant</b>	
19a. DATE OF OPERATION: <b>10</b>		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>M.</b>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <b>John M. [Signature]</b>		CHIEF MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER <b>X</b>		DATE SIGNED <b>11-21-55</b>	
23. BURIAL, CREMATION, REMOVAL (Specify): <b>Burial</b>		DATE THEREOF <b>11/19/55</b>		NAME OF CEMETERY OR CREMATORY <b>Dorchester Memorial Park</b>		LOCATION (City, town, or county) (State) <b>Cambridge, Md.</b>	
DATE REC'D BY LOCAL REG. <b>Nov 19, 1955</b>		REGISTRAR'S SIGNATURE <b>John M. [Signature]</b>		24. FUNERAL DIRECTOR <b>LECOMPTE FUNERAL SERVICE</b>		ADDRESS <b>CAMBRIDGE, MD.</b>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

NOV 28 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10777 CERTIFICATE OF DEATH

10791

Reg. Dist. No. 116

1. PLACE OF DEATH COUNTY <b>Dorchester</b> CITY OR TOWN <b>Cambridge</b> HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Cambridge-Maryland Hospital</b>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>Maryland</b> COUNTY <b>Dorchester</b> CITY OR TOWN <b>Cambridge</b> STREET ADDRESS <b>206 Aurora St.</b>			
3. NAME OF DECEASED (First) <b>Lillie</b> (Middle) <b>Ma e</b> (Last) <b>Ruark</b> (Type or Print)				4. DATE OF DEATH (Month) <b>Nov.</b> (Day) <b>25</b> (Year) <b>1955</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Feb. 23, 1894</b>	9. AGE last birthday <b>61</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Taylors Island, Dor Co.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Samuel T. Willey</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Ann Matthews</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-07-7516</b>		17. INFORMANT & ADDRESS <b>Ottie W. Ruark, Cambridge, Md.</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 421.1 IMMEDIATE CAUSE (A) <b>Myocardial Failure</b> ANTECEDENT CAUSE(S) DUE TO (B) <b>Abortic Insufficiency</b> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <b>arteriosclerosis Generalized</b>				18. MEDICAL CERTIFICATION <b>and Renal</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>2 yrs</b> <b>2 yrs +</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>6-7</b> , 19 <b>55</b> , to <b>25 Nov.</b> , 19 <b>55</b> ; that I last saw the deceased alive on <b>Nov 25</b> , 19 <b>55</b> , and that death occurred at <b>4:45 P.</b> from the causes and on the date stated above. SIGNATURE <b>Eldridge Hubert</b> M.D. ADDRESS <b>Cambridge, Md</b> DATE SIGNED <b>11-28-55</b>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Nov. 27, 1955</b>		NAME OF CEMETERY OR CREMATORY <b>Cambridge Cemetery</b>		LOCATION (City, town, or county) (State) <b>Cambridge, Md.</b>	
24. REC'D BY REGISTRAR DATE <b>Nov. 27 1955</b>		REGISTRAR'S SIGNATURE <b>J. H. Thomas</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>R. Thomas</b>		ADDRESS <b>Cambridge, Md.</b>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

# 10777 CERTIFICATE OF DEATH

Reg. Dist. No.

1. Name of Deceased

2. Sex  
3. Age  
4. Date of Birth

5. Race

6. Occupation

7. Usual Residence

8. Place of Death

9. Date of Death

10. Time of Death

11. Cause of Death

12. Manner of Death

13. Signature of Physician

14. Signature of Registrar

15. Signature of Coroner

16. Signature of Medical Examiner

17. Signature of Burial Director

18. Signature of Funeral Home

514-CJ-2216

BUREAU V. S.

DEC 2 1955

RECEIVED

Edward R. Johnson

EXHIBIT

THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS NOT TO BE USED FOR ANY OTHER PURPOSE WITHOUT THE WRITTEN PERMISSION OF THE STATE DEPARTMENT OF HEALTH. IT IS THE POLICY OF THE DEPARTMENT TO MAKE THIS RECORD AVAILABLE TO THE PUBLIC FOR RESEARCH AND STATISTICAL PURPOSES. ANY PERSON WHOSE NAME APPEARS ON THIS CERTIFICATE IS NOT TO BE CONSIDERED DEAD UNTIL THE DEPARTMENT HAS BEEN ADVISED BY THE APPROPRIATE AUTHORITY.

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 8, See: Birth Cert.

10778

## CERTIFICATE OF DEATH

10792

Reg. Dist. No. 116

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Dorchester</b>		STATE <b>Maryland</b> COUNTY <b>Dorchester</b>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN <b>Cambridge</b>		LENGTH OF STAY (in this place) <b>Life</b>		TOWN <b>Cambridge</b>		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Cambridge Md Hospital</b>		RFD <b>#2</b>					
<b>3. NAME OF DECEASED</b> (Type or Print) <b>Betty Stanley</b>				<b>4. DATE OF DEATH</b> (Month) <b>Nov</b> (Day) <b>26</b> (Year) <b>19 55</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>single</b>		8. DATE OF BIRTH <b>1-19-58 54</b>	
9. AGE last birthday <b>1</b> yrs. <b>9</b> Months <b>9</b> Days		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Dorchester-Co-Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Reginal Stanley</b>				14. MOTHER'S MAIDEN NAME <b>Grace Wilson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <b>Grace Wilson-RFD #2-Camb., Md.</b>			
<b>18. MEDICAL CERTIFICATION</b>				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
491X IMMEDIATE CAUSE (A) <b>Bronchopneumonia</b>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify</b> that I attended the deceased from <b>Nov 14, 1955</b> , to <b>Nov 26, 1955</b> , that I last saw the deceased alive on <b>Nov 26, 1955</b> , and that death occurred at <b>11-28-55</b> M, from the causes and on the date stated above.							
SIGNATURE <b>Edwin Fassett</b>				ADDRESS (Street, city, town, state) <b>227 Pine St-Camb., Md.</b>		DATE SIGNED <b>11-28-55</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>11-28-55</b>		NAME OF CEMETERY OR CREMATORY <b>Aireys</b>		LOCATION (City, town, or county) (State) <b>Aireys-Dor-Md</b>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <b>Nov 28, 1955</b>		<b>John H. Lee</b>		<b>John H. Lee</b>		<b>High St-Camb., Md.</b>	

# 10078 CERTIFICATE OF DEATH

1. DECEASED'S NAME (Last, first, middle initial)

2. SEX (Male or Female)

3. DATE OF BIRTH (Month, day, year)

4. PLACE OF BIRTH (City, State, Country)

5. OCCUPATION (If deceased was employed)

6. MARITAL STATUS (Single, Married, Widowed, Divorced)

7. DATE OF DEATH (Month, day, year)

8. PLACE OF DEATH (City, State, Country)

9. CAUSE OF DEATH (Immediate cause)

10. MANNER OF DEATH (Natural, Accidental, Homicide, Suicide)

11. SIGNATURE OF PHYSICIAN (If deceased was under medical care)

12. SIGNATURE OF CORONER (If death was sudden or unexpected)

13. SIGNATURE OF WITNESSES (If death was sudden or unexpected)

14. SIGNATURE OF DECEASED (If deceased was capable of signing)

15. SIGNATURE OF REGISTRAR (If death was sudden or unexpected)

16. SIGNATURE OF CLERK (If death was sudden or unexpected)

17. SIGNATURE OF JURY (If death was sudden or unexpected)

18. SIGNATURE OF JUDGE (If death was sudden or unexpected)

19. SIGNATURE OF DISTRICT ATTORNEY (If death was sudden or unexpected)

20. SIGNATURE OF COUNTY CLERK (If death was sudden or unexpected)

21. SIGNATURE OF TOWNSHIP CLERK (If death was sudden or unexpected)

22. SIGNATURE OF VILLAGE CLERK (If death was sudden or unexpected)

23. SIGNATURE OF CITY CLERK (If death was sudden or unexpected)

24. SIGNATURE OF STATE CLERK (If death was sudden or unexpected)

25. SIGNATURE OF FEDERAL CLERK (If death was sudden or unexpected)

26. SIGNATURE OF POSTAL CLERK (If death was sudden or unexpected)

27. SIGNATURE OF TELEPHONE CLERK (If death was sudden or unexpected)

28. SIGNATURE OF RAILROAD CLERK (If death was sudden or unexpected)

29. SIGNATURE OF AIRLINE CLERK (If death was sudden or unexpected)

30. SIGNATURE OF MARINE CLERK (If death was sudden or unexpected)

31. SIGNATURE OF NAVY CLERK (If death was sudden or unexpected)

32. SIGNATURE OF ARMY CLERK (If death was sudden or unexpected)

33. SIGNATURE OF AIR FORCE CLERK (If death was sudden or unexpected)

34. SIGNATURE OF SPACE CLERK (If death was sudden or unexpected)

35. SIGNATURE OF OTHER CLERK (If death was sudden or unexpected)

36. SIGNATURE OF DECEASED (If deceased was capable of signing)

37. SIGNATURE OF REGISTRAR (If death was sudden or unexpected)

38. SIGNATURE OF CLERK (If death was sudden or unexpected)

1. DECEASED'S NAME (Last, first, middle initial)

2. SEX (Male or Female)

3. DATE OF BIRTH (Month, day, year)

4. PLACE OF BIRTH (City, State, Country)

5. OCCUPATION (If deceased was employed)

6. MARITAL STATUS (Single, Married, Widowed, Divorced)

7. DATE OF DEATH (Month, day, year)

8. PLACE OF DEATH (City, State, Country)

9. CAUSE OF DEATH (Immediate cause)

10. MANNER OF DEATH (Natural, Accidental, Homicide, Suicide)

11. SIGNATURE OF PHYSICIAN (If deceased was under medical care)

12. SIGNATURE OF CORONER (If death was sudden or unexpected)

13. SIGNATURE OF WITNESSES (If death was sudden or unexpected)

14. SIGNATURE OF DECEASED (If deceased was capable of signing)

15. SIGNATURE OF REGISTRAR (If death was sudden or unexpected)

16. SIGNATURE OF CLERK (If death was sudden or unexpected)

17. SIGNATURE OF JURY (If death was sudden or unexpected)

18. SIGNATURE OF JUDGE (If death was sudden or unexpected)

19. SIGNATURE OF DISTRICT ATTORNEY (If death was sudden or unexpected)

20. SIGNATURE OF COUNTY CLERK (If death was sudden or unexpected)

21. SIGNATURE OF TOWNSHIP CLERK (If death was sudden or unexpected)

22. SIGNATURE OF VILLAGE CLERK (If death was sudden or unexpected)

23. SIGNATURE OF CITY CLERK (If death was sudden or unexpected)

24. SIGNATURE OF STATE CLERK (If death was sudden or unexpected)

25. SIGNATURE OF FEDERAL CLERK (If death was sudden or unexpected)

26. SIGNATURE OF POSTAL CLERK (If death was sudden or unexpected)

27. SIGNATURE OF TELEPHONE CLERK (If death was sudden or unexpected)

28. SIGNATURE OF RAILROAD CLERK (If death was sudden or unexpected)

29. SIGNATURE OF AIRLINE CLERK (If death was sudden or unexpected)

30. SIGNATURE OF MARINE CLERK (If death was sudden or unexpected)

31. SIGNATURE OF NAVY CLERK (If death was sudden or unexpected)

32. SIGNATURE OF ARMY CLERK (If death was sudden or unexpected)

33. SIGNATURE OF AIR FORCE CLERK (If death was sudden or unexpected)

34. SIGNATURE OF SPACE CLERK (If death was sudden or unexpected)

35. SIGNATURE OF OTHER CLERK (If death was sudden or unexpected)

36. SIGNATURE OF DECEASED (If deceased was capable of signing)

37. SIGNATURE OF REGISTRAR (If death was sudden or unexpected)

38. SIGNATURE OF CLERK (If death was sudden or unexpected)

10078 CERTIFICATE OF DEATH

BUREAU V. 8

NOV 30 1955

RECEIVED



## 10794 CERTIFICATE OF DEATH

Reg. Dist. No. 176

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>Dorchester</b>	MARYLAND	STATE <b>Maryland</b>	COUNTY <b>Queen Anne</b>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>X</b> <b>Cambridge</b>	LENGTH OF STAY (in this place) <b>3yrs. 3mos. 13 days</b>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Millington</b>	<b>17X-2</b>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>16 Eastern Shore State Hospital</b>		STREET ADDRESS (If rural give location) <b>---</b>	
3. NAME OF DECEASED: (First) (Middle) (Last) <b>Harry (Alias - Stant Payne) --</b>		4. DATE (Month) (Day) (Year) OF DEATH: <b>11 14 1955</b>	
5. SEX: <b>Male</b>	6. COLOR OR RACE: <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Widowed</b>	8. DATE OF BIRTH: <b>January 23, 1883</b>
9. AGE last birthday: <b>72</b> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>--</b>	
11. BIRTHPLACE (State or foreign country): <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME: <b>Jonathan Stant</b>		14. MOTHER'S MAIDEN NAME: <b>Amanda Griffith</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <b>No --</b>		16. SOCIAL SECURITY NO. <b>--</b>	
17. INFORMANT & ADDRESS: <b>RECORDS: Eastern Shore State Hospital</b>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
410X IMMEDIATE CAUSE (A) <b>Coronary Occlusion</b>			<b>7 hrs.</b>
ANTECEDENT CAUSE (S) (B) <b>Myocardial Stenosis</b>			<b>over 3 yrs.</b>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <b>Coronary Arterio Sclerosis</b>			<b>over 3 yrs.</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <b>0</b>	19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>4-12</b> , 19 <b>54</b> , to <b>11-14</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>11-14</b> , 19 <b>55</b> , and that death occurred at <b>7:15 PM</b> , from the causes and on the date stated above.			
SIGNATURE <b>Harry J. Crawford</b>		ADDRESS <b>M. D. S. S. Hospital Cambridge Md.</b>	DATE SIGNED <b>Nov. 14 1955</b>
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<b>11/18/1955</b>	<b>Chesterfield</b>	<b>Queen Anne County</b>	<b>Md.</b>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<b>Nov. 15, 1955</b>	<b>John H. Hagg</b>	<b>R. O. Edgar</b>	<b>Lane Church Hill Md.</b>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

NOV 16 1965

RECEIVED

## 10795 CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Dorchester</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Somerset</u>
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) <u>Cambridge</u>	LENGTH OF STAY (in this place) <u>4 1/2 mo.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Crisfield</u>	<u>1939-2</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Eastern Shore State Hospital</u>	STREET ADDRESS (If rural give location)		
3. NAME OF DECEASED: (First) <u>Munson</u> (Middle) <u>Swift</u> (Last)		4. DATE (Month) (Day) (Year) OF DEATH: <u>11-17-1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH: <u>4-23-23</u>
9. AGE last birthday <u>32</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>none</u>		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Maryland</u>
13. FATHER'S NAME: <u>Henry Swift</u>		14. MOTHER'S MAIDEN NAME: <u>Lillian</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <u>Eastern Shore State Hospital records.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE <u>325.5</u>			<u>6 mo +</u>
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) <u>790.1 Debility</u>			
DUE TO			
(B) <u>(Exhaustion due to chronic</u>			
DUE TO <u>mental disease and mental</u>			
(C) <u>deficiency, severe.)</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>None</u>	19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>6-27, 1955</u> to <u>11-17, 1955</u> that I last saw the deceased alive on <u>11-17, 1955</u> , and that death occurred at <u>8:15 PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>George E. Carrier</u>		M. D. <u>Cambridge, Md</u>	DATE SIGNED <u>11-17-55</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>Nov. 20, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Sunridge</u>	LOCATION (City, town, or county) (State) <u>Crisfield Md.</u>
DATE REC'D BY LOCAL REGISTRAR <u>Nov. 18, 1955</u>	REGISTRAR'S SIGNATURE <u>John R. ...</u>	24. FUNERAL DIRECTOR <u>Bradshaw &amp; Sons</u>	ADDRESS <u>Crisfield Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

NOV 21 1955

RECEIVED

## 10796 CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Dorchester</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Somerset</u>
CITY (If outside corporate limits, write RURAL or and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
<u>X</u> TOWN <u>rural Cambridge</u>	<u>28 yrs.</u>	OR TOWN <u>Crisfield</u> <u>19-39-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Eastern Shore State Hospital</u>		STREET ADDRESS (If rural give location)	

3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH: <u>Nov. 8</u> <u>1955</u>	
<u>EDWARD</u> <u>TAYLOR</u>			
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>single</u>	8. DATE OF BIRTH: <u>8/2/02</u>
9. AGE last birthday: <u>53</u> yrs.		IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS.: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>farm laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Md.</u>
13. FATHER'S NAME: <u>William T. Taylor</u>		14. MOTHER'S MAIDEN NAME: <u>Anna Blake</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <u>unk.</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT & ADDRESS: <u>Eastern Shore State Hospital records</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>Chronic endocarditis</u>		
ANTECEDENT CAUSE (S) DUE TO		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Chronic myocardial degeneration</u>		
DUE TO (C)		

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	
--	--

19A. DATE OF OPERATION: <u>0</u>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
----------------------------------	----------------------------------	--

21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
--	--	--

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
---	--	----------------------------

22. I hereby certify that I attended the deceased from May, 1952 to Nov. 8, 1955, that I last saw the deceased alive on Nov. 8, 1955, and that death occurred at 10:05 M, from the causes and on the date stated above.

SIGNATURE <u>Thomas T. Dudge</u>	DATE THEREOF <u>11-11-55</u>	NAME OF CEMETERY OR CREMATORY <u>St. Pauls</u>	LOCATION (City, town, or county) <u>Crisfield</u>	(State) <u>Md.</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE REC'D BY LOCAL REGISTRAR <u>Nov. 8, 1955</u>	REGISTRAR'S SIGNATURE <u>John Nace, R.D.</u>	24. FUNERAL DIRECTOR <u>Bradshaw &amp; Sons</u> ADDRESS <u>Crisfield, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

NOV 9 1955

RECEIVED



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 155 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10779

## CERTIFICATE OF DEATH

10796

Reg. Dist. No. 116

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Dorchester</u>		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>13 Cambridge</u>		LENGTH OF STAY (If in this place) <u>10 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Wingate</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>67 Cambridge-Maryland Hospital</u>				STREET ADDRESS (If rural give location) <u>Rural</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>Etna Jones Todd</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Nov. 14, 1955</u>			
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Married</u>	<b>8. DATE OF BIRTH</b> <u>May 13, 1889</u>	<b>9. AGE last birthday</b> <u>66</u> Yrs.	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	<b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>own home</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Chance, Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>	
<b>13. FATHER'S NAME</b> <u>Samuel Jones</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Sallie Willing</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>no</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>5513 Pioneer Drive Mrs. Wadell C. Harding, Baltimore, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>260X IMMEDIATE CAUSE</b> (A) <u>Coronary Thrombosis, massive</u>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>3 minutes</u>	
<b>ANTECEDENT CAUSE(S) DUE TO</b> (B) <u>Arterio Sclerosis, generalized</u>						<u>1 year +</u>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b> (C) <u>Diabetes Mellitus</u>						<u>1 year +</u>	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b> <u>None</u>				<b>19b. MAJOR FINDINGS OF OPERATION</b> <u>---</u>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/>		<b>21b. PLACE</b> (Home, farm, factory, of INJURY street, office bldg., etc.) <u>---</u>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State) <u>---</u>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) <u>---</u>		<b>21e. INJURY OCCURRED</b> White <input type="checkbox"/> Not white <input type="checkbox"/> M. <input type="checkbox"/> el work <input type="checkbox"/> el work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b> <u>---</u>			
<b>22. I hereby certify that I attended the deceased from</b> <u>11-5-55</u> , 19 <u>55</u> , to <u>11-14-55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11-14-55</u> , 19 <u>55</u> , and that death occurred at <u>12:00 noon</u> M, from the causes and on the date stated above.							
<b>SIGNATURE</b> <u>Eldridge H. Wolff</u>				<b>ADDRESS</b> (Street, city, town, state) <u>Cambridge, Md.</u>		<b>DATE SIGNED</b> <u>15 Nov 1955</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>Nov. 16, 1955</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Greenlawn Cemetery</u>		<b>LOCATION</b> (City, town, or county) (State) <u>Cambridge, Md.</u>	
<b>24. REC'D BY REGISTRAR</b> <u>Nov. 16, 1955</u>		<b>REGISTRAR'S SIGNATURE</b> <u>John H. D.</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Quinn R. Thomas</u>		<b>ADDRESS</b> <u>Cambridge, Md.</u>	

# CERTIFICATE OF DEATH

Form No. 10

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Age

Sex

Color

Marital Status

Occupation

Education

Religion

Place of Birth

Usual Residence

Place of Death

Time of Death

For 12 months

For 12 months

For 12 months

For 12 months

NO. 10

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

1. MEDICAL CERTIFICATION

2. MEDICAL CERTIFICATION

BUREAU V. S.

NOV 20 1921

RECEIVED

*Wm. H. Jones*

NOTATION TO THE REGISTRAR

NOTATION TO THE REGISTRAR  
This certificate is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Md., and a copy of it is to be sent to the local health officer of the place where the death occurred.  
NOTATION TO THE REGISTRAR  
This certificate is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Md., and a copy of it is to be sent to the local health officer of the place where the death occurred.

10780  
CERTIFICATE OF DEATH10797  
Reg. Dist. No. 116

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Dorchester</u>	MARYLAND	STATE <u>MD.</u>	COUNTY <u>TALBOT</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>13 CAMBRIDGE</u>	LENGTH OF STAY (in this place) <u>6 Mo.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u> <u>20-40-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90 GLEN BURN NURSING HOME</u>	STREET ADDRESS (If rural give location) <u>HANSON.</u>		
3. NAME OF DECEASED: (First) (Middle) (Last) <u>WILLIAM HOWARD WALKER</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>NOV. 25 1955</u>	
5. SEX: <u>MALE</u>	6. COLOR OR RACE: <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>	8. DATE OF BIRTH: <u>JAN. 22, 1876</u>
9. AGE last birthday: <u>79</u> yrs.		IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS.: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>RETIRED FARMER.</u>		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>MARYLAND.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME: <u>WM. WALKER</u>	
14. MOTHER'S MAIDEN NAME: <u>GEORGIANA TARR</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>9</u> (If Yes, give war or dates of service)	
16. SOCIAL SECURITY NO.: <u>214-28-1542</u>		17. INFORMANT & ADDRESS: <u>Mrs. Teaxord LEONARD</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage</u>			<u>3 days</u>
ANTECEDENT CAUSE (B) <u>Coronary Heart Disease</u>			<u>6 months</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Generalized arteriosclerosis</u>			<u>6 yrs.</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/22, 1955</u> , to <u>11/25, 1955</u> , that I last saw the deceased alive on <u>11/24, 1955</u> , and that death occurred at <u>3:35 PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Lawrence Maryanov</u>		M. D. <u>Cambridge, Md</u> DATE SIGNED <u>11/25/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>11-28-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>EASTON, TALBOT, MD</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Nov. 28, 1955</u>		REGISTRAR'S SIGNATURE <u>Maurice E. Lawrence, Jr.</u>	
24. FUNERAL DIRECTOR		ADDRESS <u>Easton, Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

NOV 30 1955

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12601

## CERTIFICATE OF DEATH

Reg. Dist. No. 116

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Dorchester</u>		STATE <u>Maryland</u> COUNTY <u>Dorchester</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN <u>Church Creek</u>		LENGTH OF STAY (In this place) <u>15 years</u>		CITY OR TOWN <u>Church Creek</u>		CITY OR TOWN <u>Church Creek</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Main Street</u>		HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Main Street</u>		STREET ADDRESS <u>Main Street</u>		STREET ADDRESS <u>Main Street</u>	
<b>3. NAME OF DECEASED</b> (First) <u>Levin</u> (Middle) <u>berry</u> (Last) <u>Wingate</u>				<b>4. DATE OF DEATH</b> (Month) <u>Nov.</u> (Day) <u>28</u> (Year) <u>1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>1873</u>	9. AGE last birthday <u>82</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>tonging oysters, etc</u>		11. BIRTHPLACE (State or foreign country) <u>Wingate</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Levin B. Wingate</u>				14. MOTHER'S MAIDEN NAME <u>Eliza Pritchett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT & ADDRESS <u>Raymond Wingate, Church Creek, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
IMMEDIATE CAUSE (A) <u>420.0 ARTERIOSCLEROTIC HEART DISEASE</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE</u>							
STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>SENILITY</u>						<u>5 yrs.</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>INTESTINAL OBSTRUCTION</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2-15-</u> <u>1955</u> , to <u>11-28-</u> <u>1955</u> , that I last saw the deceased alive on <u>11-26-</u> <u>1955</u> , and that death occurred at <u>11:00 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Robert B. Bunker</u>				ADDRESS (Street, city, town, state) <u>M.D. 9 Race St., Cambridge, Maryland 11-30</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		DATE THEREOF <u>Nov. 30, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Moore Family Cemetery</u>		LOCATION (City, town, or county) (State) <u>Wingate, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>John T. Law, R.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth R. Hoops</u>		ADDRESS <u>Cambridge, Md.</u>	
DATE <u>Feb. 9, 1956</u>							

10 FEB 1955

RECEIVED



1

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10781

**CERTIFICATE OF DEATH**

10798

Reg. Dist. No. 116

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
13 TOWN <u>Cambridge</u>		Life		TOWN <u>Cambridge</u>		13	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
00 313 High St				313 High Street			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) (Middle) (Last)				(Month) (Day) (Year)			
<u>Lemuel Woolford</u>				<u>Nov 27</u>		<u>19 55</u>	
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
<u>Male</u>		<u>Negro</u>		<u>Widower</u>		<u>Dec-8-1872</u>	
9. AGE last birthday		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>82</u> yrs.		<u>Plasterer</u>		<u>Dorchester-Co-Md.</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>William Woolford</u>				<u>Lara Hughes</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<u>- - - - -</u>				<u>- - - - -</u>		<u>Carroll Hall-High St-Camb., Md.</u>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
420.0 IMMEDIATE CAUSE (A) <u>Cardiac Decompensation</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive Arteriosclerotic Heart Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May</u> , 19 <u>55</u> , to <u>Nov 27</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Nov 27</u> , 19 <u>55</u> , and that death occurred at <u>11</u> M, from the causes and on the date stated above.							
SIGNATURE		ADDRESS (Street, city, town, state)				DATE SIGNED	
<u>J. Edwin Fasset</u>		<u>227 Pine St-Camb., Md.</u>				<u>November 29, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12-1-55</u>		<u>Bethel Cemetery</u>		<u>Cambridge-Dor-Co-Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Nov 29 1955</u>		<u>J. H. Stolar, Jr.</u>		<u>J. H. Stolar, Jr.</u>		<u>High St-Camb., Md.</u>	

# CERTIFICATE OF DEATH

FILE NO.

PLACE OF DEATH

NAME OF DECEASED

SEX

DATE OF BIRTH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

EDUCATION

RELIGION

OCCUPATION

USUAL RESIDENCE

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF INTERMENT

NAME OF INTERMENT

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CLERGYMAN

NAME OF CHURCH

NAME OF CEMETERY

NAME OF GRAVE

NAME OF BURIAL

NAME OF CREMATION

NAME OF CREMATOR

NAME OF CREMATION

NAME OF CREMATION

NAME OF CREMATION

NAME OF CREMATION

NAME OF CREMATION

NAME OF CREMATION

NAME OF CREMATION

NAME OF CREMATION

NAME OF CREMATION

NAME OF CREMATION

NAME OF CREMATION

NAME OF CREMATION

NAME OF CREMATION

NAME OF CREMATION

NAME OF CREMATION

NAME OF CREMATION

NAME OF CREMATION

NAME OF CREMATION

NAME OF CREMATION

NAME OF CREMATION

NAME OF CREMATION

NAME OF CREMATION

NAME OF CREMATION

NAME OF CREMATION

NAME OF CREMATION

NAME OF CREMATION

NAME OF CREMATION

NAME OF CREMATION

NAME OF CREMATION

NAME OF CREMATION

NAME OF CREMATION

NAME OF CREMATION

NAME OF CREMATION

NAME OF CREMATION

NAME OF CREMATION

NAME OF CREMATION

NAME OF CREMATION

NAME OF CREMATION

NAME OF CREMATION

NAME OF CREMATION

NAME OF CREMATION

NAME OF CREMATION

NAME OF CREMATION

NAME OF CREMATION

NAME OF CREMATION

NAME OF CREMATION

NAME OF CREMATION

NAME OF CREMATION

NAME OF CREMATION

NAME OF CREMATION

NAME OF CREMATION

NAME OF CREMATION

NAME OF CREMATION

NAME OF CREMATION

NAME OF CREMATION

NAME OF CREMATION

NAME OF CREMATION

NAME OF CREMATION

NAME OF CREMATION

RECEIVED

RECEIVED  
NOV 30 1955  
BUREAU V. S.

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10799

## 10797 CERTIFICATE OF DEATH

Reg. Dist. No. 116

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Dorchester</u>		STATE <u>Maryland</u> COUNTY <u>Dorchester</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
OR TOWN <u>Linkwood</u>		LENGTH OF STAY (in this place) <u>Life</u>		OR TOWN <u>Linkwood, Md.</u>		OR TOWN <u>Linkwood, Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
(First) <u>Melvin</u> (Middle) <u>Leon</u> (Last) <u>Young</u>				11 8 19 55			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>Negro</u>	<u>Married</u>	<u>2-22-1916</u>	<u>39</u> yrs.	<u>8</u> Months	<u>8</u> Days	<u>8</u> Hours <u>55</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
				<u>Dorchester-Co-Md.</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Robert Young</u>				<u>Maude Rowley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
		<u>214-16-4333</u>		<u>Mrs Mary E. Woolford-Linkwood, Md.</u>			
<b>18. MEDICAL CERTIFICATION</b>						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
197X IMMEDIATE CAUSE (A) <u>Rhabdomyo Sarcoma Generalized Metastasis</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb. 14, 1955</u> , to <u>Nov. 8, 1955</u> , that I last saw the deceased alive on <u>Nov. 8, 1955</u> , and that death occurred at <u>11-13-55</u> M, from the causes and on the date stated above.							
SIGNATURE		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Melvin Young</u>		<u>11-13-55</u>		<u>Salem Cemetery</u>		<u>Salem, Maryland</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Burial</u>				<u>John Shaw, M.D.</u>		<u>Cambridge, Md.</u>	
DATE <u>Nov. 11, 1955</u>		REGISTRAR'S SIGNATURE		FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	

10789

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

# 10789 CERTIFICATE OF DEATH

1. NAME OF DECEASED John Doe		2. PLACE OF DEATH Home	
3. SEX Male		4. AGE 45	
5. RACE White		6. DATE OF DEATH 10-15-1957	
7. TIME OF DEATH 10:00 AM		8. CAUSE OF DEATH Heart Disease	
9. DISEASE OR INJURY Myocardial Infarction		10. SIGNATURE OF PHYSICIAN Dr. J. K. Smith	
11. SIGNATURE OF WITNESSES John Doe, Sr.		12. SIGNATURE OF REGISTRAR Maryland State Department of Health	
13. PLACE OF BIRTH Baltimore, Md.		14. DATE OF BIRTH 10-15-1912	
15. OCCUPATION Teacher		16. MARITAL STATUS Married	
17. EDUCATION High School		18. RELIGION Roman Catholic	
19. PREVIOUS ILLNESS Hypertension		20. MEDICATION None	
21. ALCOHOLIC BEVERAGE None		22. TOBACCO None	
23. OTHER None		24. SIGNATURE OF DECEASED None	
25. SIGNATURE OF NEXT OF KIN John Doe, Sr.		26. SIGNATURE OF BURIAL None	
27. SIGNATURE OF CREMATION None		28. SIGNATURE OF INTERMENT None	
29. SIGNATURE OF FUNERAL HOME None		30. SIGNATURE OF CEMETERY None	
31. SIGNATURE OF CHURCH None		32. SIGNATURE OF MINISTRY None	
33. SIGNATURE OF OTHER None		34. SIGNATURE OF OTHER None	
35. SIGNATURE OF OTHER None		36. SIGNATURE OF OTHER None	
37. SIGNATURE OF OTHER None		38. SIGNATURE OF OTHER None	
39. SIGNATURE OF OTHER None		40. SIGNATURE OF OTHER None	
41. SIGNATURE OF OTHER None		42. SIGNATURE OF OTHER None	
43. SIGNATURE OF OTHER None		44. SIGNATURE OF OTHER None	
45. SIGNATURE OF OTHER None		46. SIGNATURE OF OTHER None	
47. SIGNATURE OF OTHER None		48. SIGNATURE OF OTHER None	
49. SIGNATURE OF OTHER None		50. SIGNATURE OF OTHER None	
51. SIGNATURE OF OTHER None		52. SIGNATURE OF OTHER None	
53. SIGNATURE OF OTHER None		54. SIGNATURE OF OTHER None	
55. SIGNATURE OF OTHER None		56. SIGNATURE OF OTHER None	
57. SIGNATURE OF OTHER None		58. SIGNATURE OF OTHER None	
59. SIGNATURE OF OTHER None		60. SIGNATURE OF OTHER None	
61. SIGNATURE OF OTHER None		62. SIGNATURE OF OTHER None	
63. SIGNATURE OF OTHER None		64. SIGNATURE OF OTHER None	
65. SIGNATURE OF OTHER None		66. SIGNATURE OF OTHER None	
67. SIGNATURE OF OTHER None		68. SIGNATURE OF OTHER None	
69. SIGNATURE OF OTHER None		70. SIGNATURE OF OTHER None	
71. SIGNATURE OF OTHER None		72. SIGNATURE OF OTHER None	
73. SIGNATURE OF OTHER None		74. SIGNATURE OF OTHER None	
75. SIGNATURE OF OTHER None		76. SIGNATURE OF OTHER None	
77. SIGNATURE OF OTHER None		78. SIGNATURE OF OTHER None	
79. SIGNATURE OF OTHER None		80. SIGNATURE OF OTHER None	
81. SIGNATURE OF OTHER None		82. SIGNATURE OF OTHER None	
83. SIGNATURE OF OTHER None		84. SIGNATURE OF OTHER None	
85. SIGNATURE OF OTHER None		86. SIGNATURE OF OTHER None	
87. SIGNATURE OF OTHER None		88. SIGNATURE OF OTHER None	
89. SIGNATURE OF OTHER None		90. SIGNATURE OF OTHER None	
91. SIGNATURE OF OTHER None		92. SIGNATURE OF OTHER None	
93. SIGNATURE OF OTHER None		94. SIGNATURE OF OTHER None	
95. SIGNATURE OF OTHER None		96. SIGNATURE OF OTHER None	
97. SIGNATURE OF OTHER None		98. SIGNATURE OF OTHER None	
99. SIGNATURE OF OTHER None		100. SIGNATURE OF OTHER None	

RECEIVED

BUREAU A. B.

10-15-1957

NOTICE